

Allied Health Professions' Office of Queensland

Occupational Therapy Learner Guide

Assist with the rehabilitation of clients

April 2017

Occupational Therapy Learner Guide – Assist with the rehabilitation of clients

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INTRODUCTION

Welcome to the Learning Guide for *Assist with the rehabilitation of clients*.

Learner Guide Structure

This Learner Guide has been developed specifically for Allied Health Assistants to provide the skills and knowledge required to receive and respond to rehabilitation programs developed by Allied Health Professionals

This Learner Guide contains information and activities relating to key topics to enhance learning opportunities. The guide is broken up into three topic areas with sub-topics for each. These are as follows:

Organisation Requirements:

- Policies and procedures relevant to conducting group sessions
- Legal and ethical requirements for allied health assistance work
- Record keeping practices including confidentiality requirements

Rehabilitation:

- Disease and illness
- Rehabilitation strategies
- Working in a care team environment

Service Provision:

- Information and resources to assist with the rehabilitation of clients
- Client care model
- Scope of practice

Each topic includes sub-topics which cover the essential knowledge from the unit of competency. You will be asked to complete the activities in each topic to support your learning. These activities address the essential skills from the unit of competency and will be part of your assessment.

Throughout the guide, you will be given the opportunity to work through a number of activities, which will reinforce your learning and help you improve your communication and organisation skills, manual handling skills and ability to apply therapeutic exercise practices. Take time to reflect during the module on how you may be able to apply your new knowledge and skills in your role as an allied health assistant.

Learning requirements

It is important that you have an allied health workplace supervisor who has agreed to support in your study. Regular clinical supervision during the course of your study should also assist you to stay “on track”, provide opportunities for your supervisor to monitor your progress, provide encouragement, and to check that you understand the information in the learning materials. This will be particularly important if you are having any specific learning difficulties.

Self Completion Checklist

The Self Completion Checklist outlines the underpinning knowledge and skills contained in each of the topics for the unit of competency you will be assessed against. You will be asked to review the list and place a tick in the box if you feel you have covered this information in each section and if you feel ready to undertake further assessment. If you have any questions about this checklist, ask your supervisor.

Recognition for Prior Learning

If you subsequently enrol in the Certificate IV in Allied Health Assistance you may be able to undertake recognition assessment for the study that you have done. To enable you to gain recognition for the learning you have undertaken in this Learner Guide, it will be necessary for you to complete the Assessment Guide associated with this unit of competency. The assessment activities in this Assessment Guide must be signed off by an **occupational therapist**. Copies (Word version) of the Assessment Guide can be obtained by contacting the Allied Health Professions' Office of Queensland via e-mail AH_CETU@health.qld.gov.au



Please Note

Due to the varied environments in which allied health assistance is carried out, the terms ‘patient’ and ‘client’ are used interchangeably throughout this resource. Please use your organisation’s preferred term when performing your duties.

Symbols

The following symbols are used throughout this Learner Guide.



Important Points – this will include information that is most relevant to you; statistics, specific information or examples applicable to the workplace.



Activities – these will require you to reflect on information and workplace requirements, talk with other learners, and participate in a role play or other simulated workplace task. You may use the space provided in the Learner Guide to write down a draft response. Record your final answer in the Assessment Guide.



Further Information – this will include information that may help you refer to other topics, complete activities, locate websites and resources or direct you to additional information located in the appendices.



Case Studies – these will include situations or problems for you to work through either on your own or as a group. They may be used as a framework for exploration of a particular topic.



Research – this refers to information that will assist you complete activities or assessment tasks, or additional research you may choose to undertake in your own time.

LEARNING OUTCOMES

As an Allied Health Assistant assisting with the rehabilitation of clients you will be required to perform the following tasks.

1. Plan to deliver a rehabilitation program by:
 - Obtaining information (which may include rehabilitation plans, client care plan, case notes or Allied Health Professional instructions) about the rehabilitation program from an Allied Health Professional
 - Consulting an Allied Health Professional about the rehabilitation plan requirements and desired client outcomes
 - Identifying program requirements outside scope of role and responsibilities as defined by the organisation and discuss with Allied Health Professional
 - Identifying and confirm impact of therapeutic program's contribution to the overall rehabilitation outcome for the client
 - Obtaining information about medical and psychosocial conditions that may impact on rehabilitation outcomes for client
 - Determining client availability according to organisation protocols

2. Assist with the development of a rehabilitation program by:
 - Assisting professional to work with client to identify current skills (which may include ADLs, personal care, mobility, work or recreation) and abilities and how these can be built upon to manage their lives and environment (which may include home, rehabilitation setting, hospital, school or work) more effectively
 - Assisting professional to work with client to identify their needs and priorities in terms of specific skills required to manage their lives in the short and medium term
 - Identifying skills that need to be developed that are outside scope of role and responsibilities as defined by the organisation and refer to the Allied Health Professional
 - Assisting professional to work with client to develop goals that will enable work at the client's own pace to acquire, regain and retain skills for daily living
 - Supporting the client to identify methods that will build upon their strengths when developing, regaining or retaining skills important for daily living
 - Following specific directions from Occupational Therapist for the fabrication and adaptation of therapeutic aids and equipment
 - Maintaining and updating resources for occupational therapy and recreational programs.
 - Working with professional and client to determine methods of evaluating the effectiveness of activities and methods

3. Assist with the delivery of a rehabilitation plan by:

- Gathering the equipment and materials to deliver the program, in line with client needs, specifications of the Allied Health Professional and legislative and organisation guidelines (which may include organisational policy and procedures or manufacturer specifications)
 - Checking safety and efficiency of any equipment and materials
 - Supporting client to carry out activities in ways that promote safety, involvement and confidence, and adhere to the cultural and spiritual beliefs and preference of the client.
 - Providing constructive feedback to client about involvement in activities
 - Modifying approaches if client becomes distressed, in pain or communicate their desire to stop or amend the activity
 - Seeking advice if safety issues arise, does not wish to continue, is distressed or in pain or if conflict arises with client
 - Assisting professional to work with client to review progress
 - Monitoring the use of adaptive equipment (may include hand splints, specialised cutlery or specialised seating) as directed by an Occupational Therapist
4. Clean and store equipment and materials by
- Cleaning equipment and materials according to manufacturer’s requirements
 - Storing equipment and materials according to manufacturer’s requirements and organisation protocols
 - Reporting equipment faults to appropriate person
5. Document client information by:
- Using accepted protocols to document information relating to the rehabilitation program in line with organisation requirements
 - Providing regular feedback to the client’s care team
 - Using appropriate terminology to document symptomatic expression of identified problems related to the rehabilitation program

LEARNING TOPICS

This table below outlines the relationship between the topics presented in this Learner Guide and the Essential Knowledge required for completion of the unit of competency.

Topics	Essential Knowledge
Organisation Requirements	<ul style="list-style-type: none"> • Knowledge of codes of practice for work in occupational therapy • Legal and organisation requirements on equity, diversity, discrimination, rights, confidentiality and sharing information when supporting a client on a rehabilitation program • A working knowledge of record keeping practices and procedures in relation to rehabilitation programs • OHS policies and procedures that relate to the Allied Health Assistant's role in implementing rehabilitation programs • Infection control policies and procedures that relate to the Allied Health Assistant's role in implementing rehabilitation programs.
Rehabilitation	<ul style="list-style-type: none"> • Strategies to support, motivate and encourage clients in a rehabilitation program • How to assist with the development, regaining and retention of skills for daily living, in conjunction with clients, carers and other members of a care team • The impact of illness on daily living and working skills on clients, carers and others • Working with client's, carers and others to: <ul style="list-style-type: none"> • identify needs • identify strategies to build on existing strengths and capacities • evaluation of progress • unmet needs
Service Provision	<ul style="list-style-type: none"> • Access to resources, aids and information for rehabilitation programs • Understanding of role within a care team and when and how to provide feedback about the client • Supervisory and reporting protocols of the organisation • Understanding of quality assurance, best practice and accreditation standards

CONTENT

1. Organisation Requirements

This topic covers information about:

- Policies and Procedures
- Legal and Ethical Requirements
- Record Keeping

Activities in this topic address the following essential skills:

- Work collaboratively with clients in the pursuit of rehabilitation outcomes in line with established rehabilitation principles and practices
- Work under direct and indirect supervision
- Follow through rehabilitation service policies and procedures
- Communicate effectively with clients in therapeutic or treatment relationship
- Communicate effectively with supervisors and co-workers.

1.1 Policies and Procedures

Within all health settings, there are many documents that outline set standards of behaviour and formalised ways of doing things. These should guide actions of staff within that setting. These may be in the form of written policies, procedures, codes of conduct or codes of ethics.

These documents exist to make sure high standards of behaviour, safety and consistent ways of doing things are maintained. They help protect both Clients and staff from questionable conduct, and support provision of efficient, effective, consistent health care. Basic knowledge of relevant policies and procedures is essential, as these documents underpin work behaviours in a health setting.

Queensland Health policies and procedures are managed in the following way:

Policy	A statement of intent to achieve a particular outcome
Policy Implementation Standard	Defines the parameters, including responsibilities and accountabilities, of implementing the policy.
Procedure	Agreed set of practices, generally sequential, to support the consistency and quality of an activity or service in more than one work unit.
Workplace Instruction	Procedures, protocols and guidelines which apply only to staff within a particular work unit.

The most current state-wide policies and procedures are located on the Queensland Health Intranet site. Current district and work unit policies, procedures and work instructions will be managed on the District intranet site or local shared drive. It is important you ensure you have access to these.

You will need to be familiar with policies and procedures that address the following:

- Supervisory and reporting protocols
- Occupational health and safety
- Infection control
- Legal and organisational requirements
- Quality assurance, best practice and accreditation standards
- Codes of practice for work in occupational therapy

Queensland Health Policies

Queensland Health policies should always be aligned with Queensland Health's 'strategic direction'. They should be in line with the state and federal legislation on the same matter and be easily accessible for those required to implement the policies (Queensland Health, 2015). On an employee level, we must apply Queensland Health policies and guidelines to our work to ensure we are providing client care that is of a high standard, safe, and accessible to all.



You do not need to be aware of all of Queensland Health's policies. However, you should have an awareness of and understanding of specific Queensland Health policies that apply to your role.

To find out more about the Department of Health's policy framework:

<https://www.health.qld.gov.au/system-governance/policies-standards/types/default.asp>

The following policies include some that you should consider when conducting your work as an Allied Health Assistant. Please note this is not an exhaustive list. There will be additional policies relevant to your particular workplace.

- Work Health and Safety Policy (July 2014)
- Anti-discrimination and vilification Policy (November 2016)
- Orientation, Induction and Mandatory Training Policy (November 2016)
- Workplace Equity and Harassment Officers Policy (May 2010)
- Performance and Development Policy (June 2014)



You should discuss with your supervisor or line manager which additional Queensland Health Policies (not listed above) are relevant to your particular workplace.

Supervisory and Reporting Protocols

Supervision refers to instructing, advising, and monitoring another person in order to ensure safe and effective performance in carrying out the duties of their position. You will be responsible for reporting to the Allied Health Professional and providing supervision to less experienced Allied Health Assistants. To successfully achieve this, you will need to identify your organisations policies that outline how to complete this in relation to your role and boundaries.

Supervision can be direct with face to face contact or indirect, such as via electronic communications e.g. telephone and videoconferencing. The method and frequency of your supervision will be determined by other factors including:

- your experience
- task maturity
- your non-clinical skill development
- your organisation's reporting protocols on Client treatment programs and progress

With your supervisor, you need to identify at what level you require direct or indirect supervision for what activities. A Performance Appraisal and Development plan (PAD) may be used by your supervisor to formally document your performance expectations, ensuring feedback and guidance and a way of jointly identifying your learning and developmental needs and activities.

Performance Appraisal and Development (PAD)

This is a process to be completed by all Queensland Health staff, which involves setting goals for improving work performance and progressing career paths. This is intended to benefit both staff and the organisation. Your PAD is usually completed once a year with a six monthly review of the goals that you set.

There is a clear process and structure for employees participating in a PAD including the use of standardised forms. Participating in PAD ensures:

- clear performance expectations for employees
- feedback and guidance on performance – both positive and negative
- joint identification of learning and developmental needs and activities

In addition, your PAD can be used to identify areas of work you would like to improve or develop. You and your manger can develop a plan about how to achieve your goal. For example, you may wish to improve your knowledge of wheelchair maintenance. In your PAD, you can record this as a goal and work out with your manager how you can learn more e.g. work-shadow another staff member or attend a workshop on the topic.

This plan is designed to be used for longer term career planning as well as short term needs. For example, perhaps you wish to work in an acute ward setting. Your manager may then plan with you how you can work towards that goal while still working in your current position.

Goals need to be relevant to your employer and their business of health care. Your manager may use your PAD to identify and discuss areas they require you to work on, including if parts of any of your work performance that may be a concern (Queensland Health, 2014).

Quality Assurance

Queensland Health has a set of policies, processes, and accountabilities that are aimed at improving client safety and the quality, effectiveness and dependability of its services. It does not replace, but is additional to, the professional self-regulation and individual accountability for clinical judgement that are an essential part of healthcare (Queensland Health, 2007).

Quality is a continuous process and you will find yourself participating in and leading quality activities within your department and unit. The guiding principles of quality are:

- respect for people
- client satisfaction
- improvement through change (plan, do, check, act quality cycle)
- management by fact
- teamwork

(Queensland Health State wide Occupational Therapy Clinical Education Program, 2007)



For more information on continuous quality improvement, see
<http://qheps.health.qld.gov.au/cqld/quality-safety/quality-improvement.htm>

Accreditation

At an organisational level, all Queensland Health services must participate in a periodic accreditation process. The National Safety and Quality Health Service (NSQHS) Standards were developed by the Australian Commission on Safety and Quality in Health Care to drive the implementation of safety and quality systems and improve the quality of health care in Australia. The 10 NSQHS Standards provide a nationally consistent statement about the level of care consumers can expect from health service organisations.

In September 2011, Health Ministers endorsed the NSQHS Standards and a national accreditation scheme. This has created a national safety and quality accreditation scheme for health service organisations. <https://www.safetyandquality.gov.au/our-work/accreditation-and-the-nsqhs-standards/>

The primary aim of the National Safety and Quality Health Service (NSQHS) Standards are to protect the public from harm and to improve the quality of health service provision.



The National Safety and Quality Health Service Standards are clearly outlined on the following website.

<http://qheps.health.qld.gov.au/psu/safetyandquality/standards/default.htm>

Review the standards and highlight those standards that you believe will apply to you in your workplace setting.

Best Practice

Best practice is a term used 'in referring to procedures which are believed to result in the most efficient provision of a product or service' (Canadian Association of Occupational Therapists, 2009). Other terms such as evidenced-based practice may also be used in this area. In the healthcare setting, you will be required to ensure your clinical practices are based on current best practice. Ways of achieving this include:

- reviewing the literature
- participating in ongoing professional development



On an employee level, you must apply Queensland Health policies and procedures to ensure that you provide client care that is of a high standard, safe, and accessible to all.

Queensland Health is committed to providing a safe working environment for all staff, clients, visitors, students and volunteers. The following Queensland Health documents outline how this is achieved:

1. Work health and safety policy statement (Queensland Health 2015, http://qheps.health.qld.gov.au/safety/safety_topics/p_statement/unsigned.pdf, viewed 13 February 2017,)

2. Work health and safety policy (Queensland Health, 2014, https://www.health.qld.gov.au/data/assets/pdf_file/0034/395764/qh-pol-401.pdf viewed 13 February 2017)

Under the Code of Conduct for the Queensland Public Service (2010) and the Queensland Workplace Health and Safety Act 2011, you have a duty of care to ensure the health and safety of yourself, colleagues, clients and members of the public. Many of the activities you carry out at work have the potential to cause harm. It is important to follow correct occupational health and safety (OHS) policies and procedures to prevent or minimise workplace injuries and harm.

Whilst delivering a client's program, it is your responsibility to put in practice these OHS policies and procedures such as:

- ensuring that the equipment, materials and environment used during programs is cleaned, correctly set up, maintained and stored appropriately
- ensuring correct client handling techniques are used when moving, positioning and transferring clients
- reporting all injuries, incidents and unsafe conditions or work practices appropriately
- reporting equipment faults to appropriate person



The Queensland Health OHS online learning packages will provide you with a summary of the Queensland Health's OHS strategic plan, policies and integrated safety management systems. These packages form part of your orientation to Queensland Health.

<http://qheps.health.qld.gov.au/safety/elearning.htm>



Activity 2 - The Quality Cycle

You have been ordering stock for the work area now for a few months, and you have some ideas about how you may be able to do this more efficiently. You think it will save time and make re-ordering easier to track. You may find it helpful to refer to the following quality cycle.

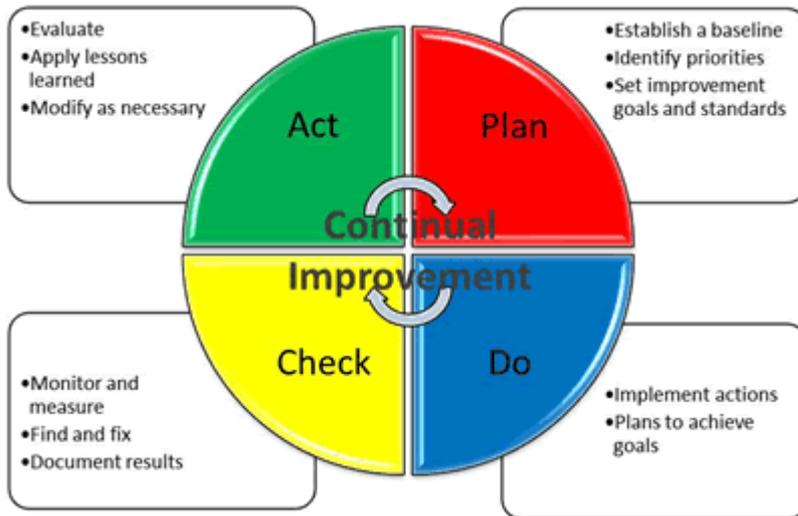


Figure 2 Quality Cycle (Queensland Health, 2017)
<http://qheps.health.qld.gov.au/darlingdowns/html/quality-safety/quality.htm>

Answer the following question. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

How do you go about doing this?

More space is provided on the next page

Infection Control

In addition to the above policies, in your role as an Allied Health Assistant you are expected to stick to infection control procedures and take responsibility for ensuring your safety as well as the safety of others.

You should have developed an understanding of infection control principles whilst completing the following units for the Certificate IV in Allied Health Assistance:

- HLTIN301C Comply with infection control policies and procedures (pre-requisite unit)
- HLTIN403C Implement and monitor infection control policy and procedures (core unit)

'Infection control practices aim to prevent infection transmission by limiting the exposure of susceptible people (hosts) to micro-organisms (agents) that may cause infection.' (Queensland Health, 2008).



The Centre for Healthcare Related Infection Surveillance and Prevention (CHRISP) is the state-wide service for Queensland Health to assist with healthcare related infection. Further information is available at:

<http://www.health.qld.gov.au/chrisp/>

Infection control policies and procedures provide the foundation for a safe health care environment for staff and clients. You will need to identify and apply the policies and procedures that relate to your role including:

- standard and additional precautions
- employee health issues e.g. immunisation
- infection surveillance
- environmental issues
- reprocessing of reusable medical and surgical equipment
- equipment and product purchases
- waste management
- building and refurbishment
- food safety
- laundry management



Many clients with infectious conditions may not be aware that they are a threat to others. Reading clients' notes comprehensively and communicating with Allied Health Professionals will assist you to prepare for group sessions that may include clients with infection precautions.

In some cases a client may not be appropriate to participate in group-based activities until clearance is provided by a medical officer.

Before seeing clients with an infection, seek further information from your supervisor or the infection control nurse. Participation in some activities like kitchen tasks may be inappropriate until the Client is cleared of any possible infection risk.



Activity 3 - Infection Control Precautions

Refer to The Centre for Healthcare Related Infection Surveillance and Prevention (CHRISP) intranet site at <http://www.health.qld.gov.au/chrisp/> and answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. As an Allied Health Assistant, you are working on an orthopaedic ward treating a Client following his total knee replacement. List 8 standard precautions that you would need to follow to limit the transmission of infectious diseases to this Client?

2. If the Client already has an infectious disease, how would you know that this is the case? What notifications would be in place? What additional precautions may be required when treating this Client?

1.2 Legal and Ethical Requirements

The policies and procedures in Section 1.1 exist to ensure Queensland Health employees follow a high standard of behaviour, safety and clinical skills.

Most Queensland Health (QH) policies and procedures are based on Australian or Queensland Government legislation or law. Some of the legislation that applies to your role as an Allied Health Assistant may include:

- Right to Information Act 2009
- Public Service Act 2008
- Building and Fire Safety Regulation 2008
- Public Health Act 2005
- Environmental Protection Act 1994
- Environmental Protection (Waste Management) Policy 2000
- Environmental Protection (Waste Management) Regulation 2000
- Disaster Management Act 2003
- Workers Compensation and Rehabilitation Act 2003
- Public Records Act 2002
- Crime and Misconduct Act 2001
- Industrial Relations Act 1999
- Work Health and Safety Act 2011
- Public Sector Ethics Act 1994
- Whistle blowers Protection Act 1994
- Anti-Discrimination Act 1991
- Public Safety Preservation Act 1986
- Health Practitioners (Professional Standards) Act 1999
- Therapeutic Goods Act 1989



Outlined below is a summary of some of the legal documents that are relevant to you as an Allied Health Assistant. It is recommended that you familiarise yourself with these documents as they apply to your organisation.

Anti-discrimination Act (1991)

Queensland Health's policies and procedures support an inclusive workplace that is free from unlawful discrimination, where all individuals are accepted and valued. This means an individual's cultural beliefs, ethnicity, religion and sexual preference are respected accepted and valued. The Anti Discrimination Act 1991 prohibits discrimination.

Clients who you will assist with rehabilitation include those from diverse backgrounds, religion, impairments and medical history, ethnicity, age and sexuality. The Human Rights and Equal Opportunities Commission Act describes discrimination as conduct which excludes or disadvantages a person based on their; race, colour, sex, religion, political opinion, national extraction or social origin. The Anti-Discrimination Act also prohibits discrimination against people based on their age, marital status, parental status, pregnancy and breastfeeding, impairment and disability, or sexual preference.



The term discrimination includes both direct and indirect discrimination. An example of direct discrimination would be choosing to spend less time working with a particular client in the group because their heavily accented language is difficult to understand. Indirect discrimination would be if you planned a group which required all clients to remove headwear. This places a rule with which a minority group (religious groups who wear veils and etc) may not be able to comply.



For a full copy of the Anti Discrimination Act 1991 refer to The State of Queensland, Office of the Queensland Parliamentary Counsel, Queensland Legislation Website:

<http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/A/AntiDiscrimA91.pdf>

Equal Employment Opportunity

Queensland Health (QH) is committed to providing a safe and equitable work environment. QH recognises that Equal Employment Opportunity (EEO) is achieved by identifying and eliminating all forms of discrimination in recruitment, selection, training, development, human resource practices and conditions of employment.

All employees are entitled to:

- be treated with fairness and respect
- work in a place free from all forms of harassment and discrimination

- have access to, and compete equitably for recruitment, selection, promotion and transfer opportunities
- have access to relevant training and development opportunities
- have all workplace grievances addressed promptly by their supervisor or other appropriate personnel and
- choose and pursue their own career path

(Queensland Health, 2009)

Privacy Act (1988)

The Privacy Act states that as a Queensland Health employee, you should only collect personal information that is directly required for the healthcare needs of clients. At commencement of most Queensland Health services, clients are provided with an overview of their rights under the Privacy Act (1988) and are asked to sign a consent form to enable Queensland Health to record and disclose health information.

Clients **DO NOT** have to provide consent to disclose personal or health information to other parties. If a client does sign the consent form, under the Privacy Act, they are able to retract their consent by providing their request in writing.

According to the Act, personal information or health information should only be used for the purpose of providing high quality healthcare. 'Health Information' means information or an opinion about a client's health or disability, or their expressed wishes about future health services. For example, in a group setting you should not discuss a client's opinion on organ donation. Also, this type of information is not limited to written information; it also includes photographs, pictures or case study information.

Right to Information Act (2009)

The Queensland Government is committed to giving the community greater access to information. The Right to Information reforms strengthen the community's right to access government-held information, unless releasing the information would be contrary to the public interest. Medical records departments will be able to direct you to an officer who deals with requests for copies of or information from medical records.



Do not show medical records to a Client without first seeking further advice from your local medical records department.

Therapeutic Goods Act (1989)

This provides for a national system of control over sales of therapeutic goods in Australia. Manufacturers may have to supply data supporting quality, safety and efficacy of the item (Therapeutic Goods Administration, 2009).

Most legal requirements focus on meeting standards set by legislation and policies. Allied health professionals working in Queensland are required to maintain state or national registration to practice. The Board sets standards of practice including adhering to professional codes of conduct and investigates any allegations of malpractice.

Public Sector Ethics Act (1994)

This Act (along with other Acts) underpins the Code of Conduct for the Queensland Public Service. The Act states that as a Queensland Health employee, you must uphold state and federal laws and carry out your work faithfully and impartially. It also states that you are responsible for operating at work honestly, fairly, and with regard to the rights and obligations to clients and colleagues.

Work Health and Safety Act (2011)

As an employer, Queensland Health has a legal obligation to ensure the workplace health and safety of employees and visitors. Employees have legal obligation to comply with their employer's reasonable instructions, including instructions for workplace health and safety, and not to wilfully place at risk the workplace health and safety of any other person.

Occupational Health and Safety (OHS) is a legislative requirement about keeping people safe in the workplace. Queensland is governed by the Queensland Government Workplace Health and Safety Act 2011.

One of the main objectives of this Act is "to secure the health and safety of workers and workplaces by protecting workers and other persons against harm to their health, safety and welfare through the elimination or minimisation of risks arising from work or from particular types of substances or plant." (Queensland Government, 2016, Work Health and Safety Act, viewed 13 February 2017, <https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/W/WorkHSA11.pdf>)



For a full copy of the Workplace Health and Safety Act 2011 refer to The State of Queensland, Office of the Queensland Parliamentary Counsel, Queensland Legislation Website:

<https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/W/WorkHSA11.pdf>

Some client sessions you will be involved in won't appear to have a high risk of injury to you, your colleagues or your clients (e.g. education sessions on returning to driving post stroke). Others will be easily identified as potentially 'risky' situations (e.g. skill retraining groups). Safety risks can include a range of things including:

- incorrect use of equipment
- out of date testing and tagging of electrical appliances
- clients who are impulsive
- unfamiliarity with evacuation procedures or Client handling issues

As an Allied Health Assistant, part of your role description will be to ensure clients receive healthcare in a safe, supportive environment. This includes taking responsibility for learning how to correctly operate, care for, and service therapy aids and equipment. You may also be expected to educate less experienced Allied Health Assistants about correct procedures.



Queensland Health (2010) outlines Client handling as:

'...any workplace activity where a person or their body part is physically moved, handled, repositioned or supported'. Specifically, Client handling tasks are those activities requiring the use of force by a worker to hold, support, reposition or transfer (lift, lower, carry, push, pull or slide) a person.

Queensland Health employees are expected to adhere to 'No Lift Principles', which are summarised as:

- the manual lifting of a client's weight is eliminated in all but exceptional or life threatening situations (such as evacuating for a fire)
- individual clients are assessed for their client handling needs at the start of service or admission
- clients should be prompted to participate and assist in Client handling tasks where possible
- where clients are unable to assist, Client handling equipment should be used
- all workers involved in direct Client care are trained and assessed as competent in the use of Client handling activities relevant to their work
- appropriate quantities of Client handling equipment that is compatible with the work environment and tasks performed is provided, used and maintained

When assisting with the rehabilitation of clients you should consider what type of equipment or aids might be required. This might occur in the form of a 'Falls Risk Assessment' or liaison with the Allied Health Professional (AHP).

As an Allied Health Assistant, workplace health and safety applies to your day to day duties in terms of making sure you are careful and use techniques with tasks such as manual handling of Clients and equipment. Another example would be labelling and removing any dangerous or broken equipment so it will not be re-used.



Find out who is the nominated workplace health and safety officer in your area – they will conduct regular audits to identify any risks in the workplace. In your work area, there should also be a register with information (Material Safety Data Sheets or MSDS) on any hazardous substances found in your area.



Visit the Queensland Health OHS online learning packages at <http://qheps.health.qld.gov.au/safety/elearning.htm>. These packages will provide you with a summary of the Queensland Health's OHS strategic plan, policies and integrated safety management systems. These packages form part of your orientation to Queensland Health.

Incidents and 'Near-Misses'

All Queensland Health facilities will have a system for reporting injuries, risks and incidents that could have or nearly happened. Examples that require reporting include the following:

- client falls or nearly falls
- staff injury or near injury at work or on the way to work

All incidents are recorded and reviewed by managers. When necessary, they are investigated by a multi-disciplinary team, usually led by the client safety officer for your district. There will be specific forms or paperwork that need to be filled out. If required, they will be able to link you to your workplace rehabilitation officer.

Any concerns or incidents must be reported to your senior staff and the senior staff member in the area where the incident occurred, as soon as possible. This is done whether staff, clients or visitors are involved or may have been involved in the incident (Queensland Health, 2009).



If yourself or a colleague are injured or have a 'near miss', seek medical help as required then report the incident immediately to your supervisor.



Reporting requirements and record keeping practices will be covered in topic 1.3 'Record Keeping'

Codes of Ethics and Codes of Conduct

Allied health professionals generally have their own profession-specific guidelines and expectations of behaviour. This often takes the form of a published code of ethics or code of conduct within which members of that profession will work.

Codes of ethics are usually based around the principles of:

- doing no harm
- acting in the best interests of the client
- setting aside your own personal values and beliefs when working with clients
- maintaining access for all to services

Codes of conduct may set out expectations such as:

- maintaining up-to-date knowledge
- maintaining the good standing of the profession
- respecting confidentiality

Occupational therapists (OT's) are required to maintain registration with the Registration Board to practice. The Board sets standards of practice including adhering to professional codes of conduct and investigates any allegations of malpractice.

Australian Association of Occupational Therapists states that 'the ethos of the occupational therapy profession and its practice requires its members to discharge their duties and responsibilities, at all times, in a manner which professionally, ethically, and morally compromises no individual with whom they have professional contact, irrespective of that person's position, situation or condition in society. The Code of Ethics is founded on the bio-ethical principles of beneficence, non-maleficence, honesty, veracity, confidentiality, justice, respect, and autonomy'(Australian Association of Occupational Therapist, 2001, p. 2).

The Occupational Therapy Code of Ethics is intended to act as clear guidance to all Occupational Therapists in their professional practice. It does not replace the principles and procedures adopted by the employers, relevant legislation nor other rights within society (Australian Association of Occupational Therapists, 2001).

These documents also help guide the OT's clinical decision-making at times when morals and values may make it unclear as to what is 'best' for a client. They help clarify between a personal opinion and a clinical decision.

The Code of Conduct for the Queensland Public Service reflects the principles of integrity and impartiality, promoting the public good, commitment to the system of

government, accountability and transparency. As an Allied Health Assistant, you need to be aware of this code and abide by it when working in a Queensland Health facility.

The Code of Conduct for the Queensland Public Service was developed in line with the government's commitment and in consultation with agencies, employees and industrial representatives. The Code was designed to be relevant for all public sector agencies and their employees and reflects the amended ethics principles and values contained in the Public Sector Ethics Act 1994.

(Public Service Commission, 2010)



Further information regarding the Code of Conduct can be found at:

<http://gheps.health.qld.gov.au/hr/codeofconduct/home.htm>



Other standards that Occupational Therapists must comply with regarding in-home modification are the Australian Standards. Information about the Australian Standards for ramps can be found on:

<https://www.legislation.gov.au/Details/F2011C00214>

1.3 Record Keeping

The Public Records Act 2002 defines a 'record' as recorded information created or received by an entity in the transaction of business or the conduct of affairs that provides evidence of the business or affairs and includes:

- a) anything on which there is writing or
- b) anything on which there are marks, figures, symbols or holes having meanings for persons, including persons qualified to interpret them or
- c) anything from which sounds, images or writings can be reproduced with or without the aid of anything else or
- d) a map, plan, drawing or photograph

(The State of Queensland, 2002)



Therefore, everything you record in the course of seeing a client is considered a public record.

As an Allied Health Assistant, you have an important role in ensuring client records comply with legal and organisational requirements. Medical records should be complete, concise and accurate notes, which act as a permanent, continuous record of client care (Queensland Health, 2007).

Record keeping includes, but is not limited to, documenting progress notes. When you conduct group sessions, additional record keeping considerations may also include:

- secure storage of client files
- correct filing of notes, correspondence and reports within medical files
- electronic client information (emails, reports and etc)
- maintaining your individual clinical statistics



Depending upon your workplace, most health service districts will have their own policy on documentation in client files. Some districts may even offer information sessions on clinical documentation. Your district health information manager can provide you with specific standards for various forms of documentation.

High quality documentation is important for all health services. Every Queensland Health employee must maintain high quality documentation standards to ensure the

best outcome for client outcomes and medico-legal accuracy (Queensland Health, 2008).

Accurate documentation of client care is a legal requirement of clinical practice (Queensland Health, 2008). In your role you will be expected to take responsibility for, or at least contribute to, a wide range of documentation including:

- assessment forms
- progress notes
- care plans
- treatment plans
- referral documentation
- handover summaries
- case conference information
- discharge summaries

At different times you will need to use the above documentation formats to provide regular feedback to your colleagues, other Queensland Health services, and external agencies. For example, if you are the sole facilitator for a group session, you must use a reliable and accurate method of reporting back to the supervising Allied Health Professional. The type of information you must provide to the Allied Health Professional includes, but is not limited to:

- significant changes to a client's physical presentation or health condition
- changes in a client's functional status
- client deviation from an activity or task prescribed by Allied Health Professional
- client motivation and overall participation in rehabilitation and overall treatment plan
- any incidents (falls, seizures and etc) or 'near misses'
- potential for onward referral within your team or external agencies
- any additional information related to the treatment and healthcare



The only information documented in the client chart should correspond directly to their healthcare. This is consistent with the Privacy Act 1988.

There are a number of record keeping practices applicable to you. These may include:

- documenting in a client's medical record and case notes
- documentation on a client's individual treatment plan and client care plan
- the Allied Health Professional's instructions

Documenting in the Client's Medical Record

Within Queensland Health, a client's clinical record (sometimes called the medical record or chart) has traditionally been the key way for capturing all clinical information relating to delivery of care to a client. The Queensland Health position statement on clinical records outlines Queensland Health's use of the clinical record.



For further information please refer to QHEPS Document 'Records Management for Administrative, Clinical and Functional Records'. This is located on the Queensland Health Intranet.

http://gheps.health.qld.gov.au/srmt/policy/rescinded_pol_rm_2012.pdf

The purpose of the medical record is to provide a:

- Record of continuity and evaluation of care
- Communication tool amongst team members
- Teaching tool
- Research and audits tool
- Medico-legal document
- Tool to evaluate the quality of care

(Staunton & Whyburn, 1997)

High Quality Documentation

The principles that promote the development of high quality documentation include:

- **Objective and accurate:** Factual evidence of the care given.
- **Concise:** Straight to the point and relevant.
- **Relevant:** Appropriate and includes evidence of the care given.
- **Complete:** Contains all aspects of care, the client's needs and provides evidence care has been given.
- **Timely:** The entry is made as soon as possible after an event of care. Recording the time of the event is important.
- **Legible:** All team members must be able to read your notes.
- **Informed consent:** must be obtained and documented.

(Queensland Health Occupational Therapy Clinical Education Program, 2009)

Documentation Standards

Standards in the development of documentation include:

- completion in black ball point pen
- each new page has the client's label on it

- don't make entries on behalf of another person
- date and time of the entry, your designation, signature and printed surname
- consider confidentiality and accessibility i.e. don't leave chart lying around
- no blank spaces left in entries
- hospital approved abbreviations only
- medical terminology used only if sure of exact meaning
- check name on medical record cover and on individual sheets before making an entry



For further information on documentation, refer to 'Allied Health Assistant: Guide to documenting in health records' at:

<http://qheps.health.qld.gov.au/alliedhealth/docs/aha/ahadocguide.pdf>

Format

You may be required to document your sessions in the medical chart or individual treatment plan. There will be specific guidelines relating to this in each individual workplace. Using a format will help you to identify what is important to document in relation to your diagnostic and therapeutic programs/treatments.

One widely used structure for documenting in the client's notes is the SOAP format.

- S = Subjective information or what the client reports
- O = Objective information or what you see
- A = Assessment of how the client's going
- P = Plan

For example: Mrs B has a goal of improved socialisation. Mrs B has presented to her therapy session for which the plan had been to attend a coffee shop and purchase a cup of coffee.

S	Mrs B reports she is 'anxious' about going to the coffee shop
O	Mrs B has presented to therapy on time wearing appropriate clothing for the visit to the coffee shop as was asked at the previous therapy session. Provided reassurance that Mrs B would be accompanied by the Allied Health Assistant.
A	Mrs B independently ordered her coffee Mrs B was observed to manage her anxiety by squeezing her therapy ball Mrs B required assistance to manage her money

P1	Continue with graded socialisation activities
P2	Assess money skills

Documentation on a client's Individual Treatment Plan (ITP)/Client Care Plan

Once the Allied Health Professional has assessed a client, they will formulate an individual treatment plan (or something of a similar name).

This document:

- outlines the client's goals
- progressively records the treatment the client receives
- is often specific to each workplace
- provides the OT's instructions

You will need to document each occasion of service on this form. Once completed, this form is filed in the client's medical records. This plan may require you to provide a treatment program to address the clients function limitations.

Common standards exist across all medical systems and facilities for writing in medical records. This ensures clear communication between the team, promoting the best client care and opportunities for evaluation of the care provided. The style of writing you need to use is formal, objective and to the point and as such you will come across a number of common abbreviations.



Ask your supervisor or medical records department for an accepted abbreviation guide available for your facility.

Standardised Assessment

Depending upon your workplace, you may be required to conduct standardised client assessments, from an approved list. A 'standardised assessment' is an assessment that is administered and scored in a consistent or standard way (Pedretti, 2001).

When you conduct these assessments, you must follow the administration guidelines (the Allied Health Professional should be able to assist locating these for individual assessments). Often there are a set of questions, in a set order, which are designed to enable consistent scoring and interpretation of scores. The questions must be recited

exactly as indicated on the assessment. Deviation from the administration guidelines may render the assessment results invalid.

After you conduct a standardised assessment with a client, you must provide these results to the Allied Health Professional who will analyse and interpret the client's score(s). When entering a progress note in the client's file, you must record that liaison with the Allied Health Professional has taken place.



Remember when you are documenting information in client notes that under the Right to Information Act 2009, individuals may apply to Queensland Health for access to their files. There is a formal procedure for this to take place. You should **never** provide this information to clients or other persons unless approved by your supervisor.

In the rehabilitation setting where clients may be seen every day for therapy, it may be common practice to document at the end of the week. For example, a summary of the week's session; dates when the client was seen, and any significant information or comments on progress would be included.

Discharge summaries, home visit reports, and assessment forms may be filed on completion rather than recording a daily update. A note in the chart to refer to a certain form for details is required to ensure the rest of the team are aware that the report exists and are able to find it (Princess Alexandra Hospital, 2007).



Activity 7 - Documentation

Read the following case study and complete the relevant chart entry for the case study. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

It may be useful to refer to 'Allied Health Assistant: Guide to documenting in health records' at

<http://gheps.health.qld.gov.au/alliedhealth/docs/aha/ahadocguide.pdf> and 'Post Traumatic Amnesia Assessment' at

http://gheps.health.qld.gov.au/cairns/docs/ot_post_traum_amnes.pdf



Case Study: Documentation

You have been asked to undertake daily Post Traumatic Amnesia Assessment (PTA) on Cooper who is a 23-year-old male. Cooper is now 3 days post motor bike accident where he lost consciousness at the scene. His PTA score has been 10/12 for the last 2 days.

When you see Cooper, he is able to name the OT who had seen him, although he reports still being unable to remember the accident. Cooper appears to be distracted when visitors entered the room and requires re-direction to continue. His PTA score today was 11/12 (orientation was 7/7, recall 4/5).

Please complete a relevant chart entry for Cooper.

Space is provided on the next page

Confidentiality of Client's Records

The use, storage of and access to a client's medical record are subject to clear guidelines by every hospital and health organisation. Part 7 of the Hospital and Health Boards Act 2011 identifies that "there is a strict duty of confidentiality imposed on the Department of Health and HHS staff in relation to the protection of confidential information. Where health information has been collected in the context of providing a health service, use and disclosure is governed by the duty of confidentiality in the HHB Act." https://www.health.qld.gov.au/_data/assets/pdf_file/0027/439164/doh-privacy-plan.pdf

Allied health assistants should follow guidelines related to the use, storage of, and access to health records. Consider the following:

1. where you leave charts in the clinical and non-clinical areas
2. are they accessible to passers-by including clients, visitors, and other staff who do not require access to them?
3. if a client/other body requests access to their/an individual's medical record refer them to the medical records department



Further information about privacy and confidentiality can be found on:

<https://www.health.qld.gov.au/global/privacy>

Storage

When assisting with the rehabilitation of clients you will often need to refer to individual client files. These files should not be accessible or visible to others. Failure to store client information appropriately is in breach of the Privacy Act 1988. This also includes transfer of client notes between rooms and facilities. If you need to leave the room where a client is waiting, client files should be secured in a lockable cabinet or case.



Case Study

You are required to conduct a group activity for clients to learn basic cooking skills. The kitchen where you are instructed to conduct the group is a short drive from where your office is based. You realise that you need to take several client's files with you to conduct the session. In order to comply with legal and organisational requirements, you use a lockable briefcase from your office to transfer the files.

Filing

It can sometimes be a confusing when you need to file the various documents in a client's file. Each health service district will however have its own 'form filing guide'. Nevertheless, there are some standard rules that you will need to follow:

- documents should be filed in reverse chronological order (most recent on top)
- all documents should be clearly labelled with the client's name, client number, date of birth and contact details
- do not use 'post it' notes or 'unauthorised' forms in the file
- any relevant documents to the client's healthcare that have not been approved by your district's forms committee must be filed in the correspondence section of notes

Electronic Information

This can include e-mails, client reports (saved electronically) and fax messages. If a client prefers to correspond via email rather than on the telephone, be mindful that you should **avoid sending confidential information by e-mail**. This also includes correspondence between health and external services. If you unlawfully forward confidential information, you and the organisation can be held legally responsible.

All fax correspondence should have a 'fax cover sheet' and all emails must include your name and job title. Queensland Health automatically adds a disclaimer on fax cover sheets and beneath your signature on e-mails. You should also ensure you do not use e-mail for critically urgent communication.



Activity 8 - Managing Confidential Information

Answer the following question. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

You are working in the outpatient department with a number of clients in the gym. Outline 5 ways in which client confidentiality should be maintained. Consider the areas of client notes, telephone calls and communication with clients, family and other health professionals.

1.

2.

3

4.

5.

Key Points

- Organisational policies and principles exist to communicate the requirements, responsibilities and accountabilities you have as an employee
- It is your responsibility to implement these in all work practices
- Six key areas arise:
 - i. Supervisory and reporting requirements
 - ii. Occupational Health and Safety
 - iii. Infection Control
 - iv. Legal and organisational requirements
 - v. Quality assurance, best practice and accreditation standards
 - vi. Codes of practice for work in OT
- Queensland Health's core policies and procedures will help guide you on how to work within relevant state or national legislations. The Queensland Health specific documents will help to translate what this legislation means for you and your workplace
- You must report any accidents or incidents or near-misses to your supervisor or line manager
- If a client is under infection control restrictions, check carefully before involving them in rehabilitation activities
- Record keeping is a legal requirement that is integral to recording and communicating a client's participation in a treatment program
- Record keeping facilitates treatment planning and communication

2. Rehabilitation

This topic covers information about:

- Disease and Illness
- Rehabilitation Strategies

Activities in this topic cover the following essential skills:

- Work collaboratively with clients in the pursuit of rehabilitation outcomes in line with established rehabilitation principles and practices
- Develop activities to promote rehabilitation activities
- Prepare and evaluate the effectiveness of rehabilitation activities
- Work under direct and indirect supervision
- Communicate effectively with clients in a therapeutic/treatment relationship
- Communicate effectively with supervisors and co-workers
- Work within a multi-disciplinary team
- Use time management, personal organisation skills and establishing priorities

2.1 Disease and Illness

Disease and illness are words that are often used interchangeably, but they can in fact have slightly different meanings. Think of a person who has eaten contaminated food, and who now has food poisoning resulting in vomiting and diarrhoea. This person definitely has an illness, but we would probably not think of them as having a disease. Let's look at some definitions:

Disease is an impairment of the normal state of the living animal or plant body or one of its parts that interrupts or modifies the performance of the vital functions (Medline Plus, 2010).

Illness is an unhealthy condition of body or mind (Medline Plus, 2010).

An 'umbrella term' term, which incorporates both of these terms, and also encompasses injury, is the term **health condition** (World Health Organisation, 2002).

Clients who require rehabilitation have frequently experienced a change in their health condition, which has had a profound effect on their life. This effect may be felt on a day-to-day basis, but may also impact significantly on their future plans and goals.

Health conditions affecting the physical body can cause problems for a person's social, psychological, emotional, and spiritual health. This is why it is important to think of the 'whole person' and their needs (often described as a 'holistic approach') when working in rehabilitation.



Having a leg amputated may lead to difficulties returning to living independently as well as participating in work and leisure activities. The physical condition (leg amputation) may lead to a psychological problem (depression), which in turn can affect the person's social life. Rehabilitation therefore needs to consider the person's social and psychological state as well as their physical needs.

Rehabilitation

Queensland Health defines rehabilitation as the process that brings about the highest level of recovery or improvement in function following the loss of function and ability from any cause.

Compare this to the following definition from the World Health Organisation:

'Rehabilitation of people with disabilities is a process aimed at enabling them to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels. Rehabilitation provides disabled people with the tools they need to attain independence and self-determination' (World Health Organisation, 2010).

As you can see, the World Health Organisation (WHO) definition mentions explicitly a person's functioning on a range of different levels, ensuring that the concept of rehabilitation extends beyond the physical consequences of illness or injury.

The Rehabilitation Setting

On a rehabilitation ward or unit, clients will usually be medically stable. That is, they are not requiring extensive medical investigations or treatment and are getting better. The team is preparing the client to leave hospital and live safely in the community. The client will be assisted and encouraged to recover from their illness or injury as best as they can, by a whole team of staff.

There are a number of differences between a rehabilitation ward and hospital ward. These may include:

- the rehabilitation environment reflects a home-like environment
- clients are encouraged to wear their normal clothes (rather than pyjamas)
- clients are encouraged to eat at a dining room table, make their own bed and shower themselves (if they are able to)
- clients being asked to manage their own time and attendance at appointments
- clients being asked to manage their own medications
- clients being given the opportunity leave the hospital for short periods to practice coping at home, for example on home visits or weekend passes
- therapy areas being easily accessed and in close proximity
- having an 'independent living unit' area, which has its own kitchen and bathroom for clients to practice managing on their own before they are discharged



Activity 9 – Rehabilitation unit

Answer the following questions on 'what makes your rehabilitation unit or area different'. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. Outline 5 differences between a rehabilitation ward and an acute ward that will benefit the client by having a positive impact on their recovery.

2. List 5 activities that the clients could be involved in during the day, which could be part of their care plan.

Activity continues on the next page

Cultural Perspectives of Disease and Illness

Many of our health services are based on the Western medical approach. Clients or families may have very different or varied beliefs regarding the meaning or cause of disability. Some differences include:

- the family or client may not place the same value as others on re-learning to do certain tasks e.g. being able to shower themselves independently
- some cultures have a strong history of caring for their own elderly or disabled at home; they may wish to take the person home and care for them despite the very high level of assistance required
- there may be a constant family presence on the ward or the family may wish to come to all therapy appointments with the person.

Cultural or religious factors may also affect factors such as:

- acceptance of treatment from male or female staff
- beliefs about healing powers of certain foods or other treatments
- priorities for recovery or time use - adjustment to the general routine of the ward or therapy programs may be required to fit in e.g. time for religious worship

There are two main components to cultural sensitivity:

- You need to be aware of your own attitudes and how they may impact on service delivery
- You need to understand any specific cultural issues that are being experienced by your clients.

(Australian Flexible Learning Framework, 2008; Trombly, 1995)

Life Span Development – Aging

Many general rehabilitation units will have a high proportion of older clients. This may be explained by the fact that diseases that require rehabilitation, such as a stroke, are more common in the older population.

Older people will frequently have other pre-existing difficulties or health problems. This can make recovery from a serious illness slower, and impacts on a client's response to rehabilitation. For example, short term memory loss may mean the person needs more supervision and assistance to participate in rehabilitation activities. Hearing or vision impairment can make it seem like someone can't figure out how to complete a task, when perhaps they did not clearly hear your instructions.

Within certain rehabilitation units, where the method of injury tends to be through trauma or accidents, a younger population of clients may be more common, for example spinal cord injury or acquired brain injury rehabilitation services (Trombly, 1995).

Common Health Conditions Requiring Rehabilitation

Stroke – Also known as cerebrovascular accident (CVA). It occurs when part of the brain does not receive sufficient oxygen due to a bleed into the brain tissue or a blood vessel being blocked and not delivering oxygen to the brain tissue. Brain cells in the area die and permanent damage may be done.

The effects of stroke range from having very mild impact on a person, to causing a massive change in their abilities. After a stroke, people may have difficulties with: walking, standing, moving arms, communicating, thinking, swallowing, seeing, feeling or controlling their bowel or bladder. They will often be very tired. Frustration, grief, anger, and depression are common. Some people may die after having a stroke.

With a stroke there are patterns of symptoms depending on which parts of the brain are affected, and how severely affected. Nevertheless, the impact on a person tends to be very individualised. For one person a stroke might mean 'ignoring' or being unaware of one side of their body, for another the main impact may be slurred speech or word-finding difficulties.

A transient ischemic attack (TIA) or 'mini-stroke' occurs when blood supply to part of the brain is temporarily cut. The person may appear to have had a stroke, but the symptoms go away over 24 hours. This is often considered a warning that the person is at serious risk of having a stroke.

(National Stroke Foundation, 2007)



For more information on stroke, visit the National Stroke Foundation website at: www.strokefoundation.org.au

Acquired Brain Injury (ABI) or Traumatic Brain Injury (TBI) – Injury to the brain from a physical force (such as a car accident, assault or sporting injury), or illness such as meningitis, lack of oxygen (drowning or suffocation or drug overdose etc) may cause impairment of cognitive, perceptual, physical and social functioning (see glossary).

The effects of ABI or TBI are similar to those of a stroke, but tend to be more 'global', meaning that a large proportion of the brain is affected, not just the area around a bleed or blockage. Swelling of the brain after TBI can also worsen the effects of injury the increased pressure within the skull can 'squeeze' the brain, reduce blood flow and affect brain structures vital for maintaining basic life functions such as breathing.



For more information on ABI/TBI, visit the Brain foundation website at: www.brainfoundation.org.au

Spinal Cord Injury (SCI) – Spinal cord injury is damage to the spinal cord that results in a loss of function such as mobility or feeling. Frequent causes of damage are trauma (e.g. car accident, falls or diving) or disease (e.g. polio, spina bifida or Friedreich's Ataxia). Spinal cord injury is commonly referred to as either complete or incomplete. Quadriplegia/tetraplegia is loss of function below the neck or Paraplegia is loss of function below the chest. In a complete spinal cord injury there are no signals below the point of injury between the brain and the body— no sensation and no voluntary movement. A person with an incomplete injury may be able to move one limb more than another, may be able to feel parts of the body that cannot be moved, or may have more functioning on one side of the body than the other.



For more information on SCI, visit the Spinal Cord injuries Australia website at: www.scia.org.au

Degenerative Neurological Diseases



For more information on Degenerative neurological disorders, including the ones below, visit the Brain Foundation website at: www.brainfoundation.org.au

Guillain-Barre Syndrome – A condition where a person's own immune system 'attacks' the peripheral nervous system, quickly producing weakness or muscle wasting and sensory loss. This is called an 'auto-immune' condition. The peripheral nervous system does not include the spinal cord or the brain. Guillain-Barre often follows a viral chest or gut infection, but why it occurs in some people and not others is not known. Symptoms depend on the nerves affected. Most clients recover within a few weeks or months, although some are left with long-term muscle weakness.

Multiple Sclerosis - is a progressive disease in which the nervous system is irreversibly damaged, again due to attack from the body's own immune system. Symptoms may fluctuate over time or just continue to become worse. As this condition can attack the peripheral nervous system, the spinal cord and the brain, symptoms can vary greatly from weakness and sensory loss to effects on thinking, memory and psychological state, or changes in personality and behaviour.



For more information on multiple sclerosis, visit the MS Australia website at: <http://www.msaustralia.org.au>

Parkinson's Disease – is a slow, progressive, degenerative disease of the central nervous system affecting adults. The part of the brain controlling movement does not work properly. What causes Parkinson's disease is not really known. Symptoms easiest to observe include tremor, stiffness, slow movements and difficulty with starting movement, but Parkinson's disease may also affect thinking, mood and behaviour.

Orthopaedic Conditions

Total Hip Replacement (THR) or Total Knee Replacement (TKR) – the client's joint is replaced with an artificial one, usually to relieve pain or improve movement.

Fractured Neck of Femur (NOF) – is commonly called a 'broken hip' and often requires surgery to be stabilised or 'fixed'.

Arthritis – common types are osteoarthritis (OA) or rheumatoid arthritis (RA). Arthritis causes aching, painful joints and may also affect other tissues. Symptoms may come and go but may gradually worsen over time. Osteoarthritis is more related to 'wear and tear' and tends to affect the large weight-bearing joints, such as hips, knees, and the joints of the spine. Rheumatoid arthritis is another 'autoimmune' condition, generally starting in small joints like finger and toe joints. RA can result in significant pain and deformity due to destruction of the joints involved.

Amputation – is full or partial loss of a limb/s either through accidents or because of surgery.



For more information on General Orthopaedic conditions, visit the American Academy of Orthopaedic Surgeons website at: <http://www.orthoinfo.aaos.org>

General De-conditioning or Multiple Medical Conditions – prolonged illness and hospitalisation can lead to loss of fitness. The person may need more time to recover and get stronger, or learn new ways of doing things, before being safely able to leave hospital. Clients may have chronic heart or lung conditions, or have had multiple or extensive surgeries (Pedretti, 2001).

International Classification of Functioning, Disability and Health (ICF)

This is a system used by the World Health Organisation to classify health and health-related domains. It considers a person's functioning or disability as an interaction between health conditions, the environment and personal factors.

Below is a list of some common classifications:

- impairment - problems in body function and structure, such as significant changes or loss
- activity - the execution of a task or action by an individual
- activity limitation - difficulties an individual may have in performing activities
- participation - involvement in a life situation
- participation restrictions - problems that may be experienced in involvement in life situations.

A major illness or health problem does not necessarily result in a major activity limitation. The environment a person lives and works in, as well as other skills that they have may allow them to continue their daily tasks despite the illness. A minor health problem for another person, with different personal skills or qualities, working in a different physical environment, may lead to a participation restriction (problems continuing their daily tasks).

(Australian Institute of Health and Welfare, 2004)

Adjustment to Change and Stages of Grieving

Responses to illness and disability vary between people. One person may be devastated by the loss of a finger, whereas another may seem to adapt well to losing the use of their legs. Loss of hearing to someone who is a musician may have a different meaning for someone than for another person who generally works alone on a computer.

Generally, a severe illness impacts all aspects of a person's daily life, often affecting psychological state, and physical and cognitive abilities. This in turn can stress relationships with family, carers or friends. Many clients in a rehabilitation unit may have recently undergone major disruption to their life, for example: being very unwell or nearly dying.



Response to major life trauma may often include the stages of grieving as the person adjusts to abilities or life roles they may have lost.

Responses may include:

- shock
- disbelief
- denial
- numbness
- grief
- mourning
- anger
- bargaining
- depression
- acceptance

It may take weeks, months or years to work through such emotions and adapt to the changes in lifestyle and conditions. It may be helpful to:

- encourage family and friends to continue to spend time with the person and support them by listening or asking how they are
- listen to the client
- accept and acknowledge all feelings
- offer comfort and reassurance without trying to make the loss seem smaller

(Trombly 1995; Smith & Segal, 2009)



Activity 11 - Reactions to Illness or Injury

This activity builds upon the case study in Activity 10.



Case Study: John

John has now been admitted to the hospital with a relapse of multiple sclerosis (MS). He has severe weakness in his arms and legs. John is experiencing difficulty with using cutlery to eat his meals and is requiring assistance to transfer into the chair. John is on medications and participates in rehabilitation. You are working as an Allied Health Assistant with John's daily program. John is resistive to attend the gym for his rehabilitation.

Please answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. What responses to his major life trauma is John experiencing?

2. Recognising John's need to adjust to living with MS, how could you as an Allied Health Assistant help John in this situation?

2.2 Rehabilitation Strategies

Rehabilitation is ongoing care and treatment, which specialises in returning a person to maximum functioning. It may occur in the 'inpatient' or 'outpatient' hospital setting. This period can last anywhere from around two weeks to six months or more. The time taken depends on the illness, recovery and time taken for the person to reach a functional level at which they can leave hospital.

Community Rehabilitation

Rehabilitation may continue once the person is at home, in the community setting. This may involve:

- home exercise programs
- home visits from community-based rehabilitation services
- attendance at facilities for appointments
- home modifications
- provision of equipment
- education of clients, carers and families
- arrange support services (such as 'Meals on Wheels')

(World Health Organisation 2017)

Inpatient Rehabilitation

Before being accepted for transfer to a rehabilitation ward from an acute ward, clients will usually be assessed by the doctor or other members of the rehabilitation team. This is to determine if they are likely to benefit from a stay in the rehabilitation ward.

A client may be more likely to benefit if:

- they are medically stable (well enough to participate in therapy)
- they have the ability to learn
- they are willing to participate and motivated to improve
- rehabilitation is likely to change the discharge location, e.g. prevent unnecessary admission into a nursing home

For some health conditions, the amount of recovery is very difficult to predict. It will depend on the amount of natural recovery or healing as well as medical and therapeutic intervention.

In the case of stroke, the brain is often able to adapt, meaning that recovery can continue to occur over many years. The majority of recovery however will be seen in the initial few months or year, after which improvements tend to slow. Small changes

are still possible, so many clients will benefit from a maintenance program of exercises in the long-term.

Some clients may recover very quickly with little input and others may not regain many skills despite the teams' best efforts. This variation may be related to the severity of the stroke, or the part of brain it has affected. Rehabilitation is usually stopped and the client discharged when there are no more significant changes occurring.

Occasionally a person may benefit from a short period of therapy in the years after their initial injury, such as if they have been unwell, or if their situation changes. An example of this might be a young mother who has had a stroke resulting in weakness in one side of her body. If she subsequently has another baby, she may need additional rehabilitation to teach her 'one handed nappy changing', or how to carry her baby safely.

It remains of key importance that the client is as involved and engaged as possible in their own therapy programs. It is helpful if family or carers are able to reinforce ideas or strategies at home as well (National Stroke Foundation, 2017).

Helping with Rehabilitation Activities

As an Allied Health Assistant, you will often be asked to carry out the rehabilitation program prescribed or set by an Allied Health Professional. This may include:

- a list of activities or tasks for the client to complete in therapy sessions
- daily living tasks that the client is able to learn to do again themselves
- exercises to practice
- training a client to use special new equipment in order to complete tasks
- functional re-training, e.g. learning how to do things like getting dressed, walking, talking or making a cup of tea again. The goal or aim may often be for the person to slowly learn to be able to do these tasks independently



Activity 12 - What Rehabilitation Activities Do You Do?

Answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. List 5 settings where rehabilitating, retraining or improving a client's ability may occur.

2. How does the Occupational Therapist decide upon activities to use?

Recovery of Skills

Recovery of skills will usually require frequent, repetitive practice at a task. The client is usually asked to complete as much of the task as they are capable of each time, and then be assisted where necessary to finish it off.



'Breaking-down' of tasks can make an activity more achievable for the client. Breaking a task down into small steps is often a key part of the rehabilitation program.

The client may then be asked to do the first part of the task and the Allied Health Assistant finishes it off (forward chaining). Alternatively, sometimes it is easier and more motivating for the Allied Health Assistant to start the task, and then ask the client to finish it off (backward chaining). In future sessions, the client may be asked to do more steps each time until they can finish the whole activity on their own.



Case Study

You have been asked to assist a client to put on a shirt. You first ask them to put the shirt on; you help with the top button to get the task started, then you would ask the client to practice using both hands to do up the rest of the buttons themselves. In time, they may be able to reach high enough to do up the top button themselves.

Therapy tasks linked to the above case study may include practicing lifting their hands to scratch their chin, pin items to a cork board, or practice lifting a cup to their mouth to help strengthen the movements involved.

Instructions you are given may vary widely between settings, the simplicity of the task, or how much experience you have. It may be helpful to ask for a plan or list in writing. The rehabilitation program should have some clear goals or aims, with lists or a plan of what activities or exercises are to be used to achieve those goals.

Goals may be broken down into long-term or short-term goals. For example, the aim for the next week for the client may be for them to be able to hold a spoon for 20 seconds. The long-term aim over the next month may be for the client to bring a loaded spoon to their mouth to feed themselves.

Therapy sessions are often conducted in different ways for example:

- group exercises for those clients working on similar activities
- embedded into the client's daily routine, for example making breakfast
- independent practice by clients; try sharing with family members (with the client's permission) of what is being practiced in therapy, so they can help encourage or help the client to continue working on their therapy programs

Communicating with the client about how they are going (feedback), or giving the client a clue when needed as to what comes next is essential. Often it is best to give people plenty of time to complete a task or to recognise and fix an error. However, you will need to pay attention and step in to end the frustration if it is clearly something they are not able to do.

Providing Constructive Feedback

Constructive feedback is given with the intention of helping someone to improve their performance. Therefore this involves providing suggestions for how to improve performance as well as pointing out what didn't work or what went wrong.

When giving feedback to clients you need to consider:

- that your job is to help clients improve, so offer a solution or suggestion as well as pointing out an error
- keeping a positive outlook by focusing on what the client could do, rather than the problem (what they could not do) and suggest ways to build on what they achieved



Case Study

A client is attempting to dress themselves after the shower and the only part the client managed independently, was to pull on their shirt. You point out that they were able to do part of the task themselves and that they have mastered an important step or part of the task. You then set another task (such as pulling up their trousers) for their next attempt which builds upon what they just achieved.

- Balance any negative with positive feedback – it shouldn't always be negative feedback
- Focus on what has potential to be changed. For example, a client living with dementia may not ever remember to attend their appointment on time. There is little to be gained by pointing this out to them, but perhaps instead you could focus on strategies that may assist the client to remember their appointments.
- Do not blame the problem on the client or put the client down personally
- Help clients to analyse their own performance and what could work better. This allows some dignity and self-respect.
- Encourage clients to 'do more of' what works well, and 'less of' what is not working



Case Study

You are working with a client who is practising using a spoon and in the process they are spilling a large amount of food. The client is focussing on the amount they are spilling and not the action of lifting the spoon. You feedback to the client the importance of concentrating more on the task, for example, 'let's pay less attention to whether you have spilled any food and more to whether you can lift your hand to your mouth'.

Timing of Feedback

Another aspect to consider with feedback is timing as well as the amount of feedback. Take care not to overload the client with feedback.

- give specific feedback soon after the task, as this may be better remembered and easier to use for change. Point out exactly what was good and what could work better
- provide regular feedback so that clients learn to expect and accept feedback as a routine part of therapy
- providing feedback during an action or task may be needed at times. Keep this to short, clear sentences or just a few words. The client may struggle to concentrate on what you're saying as well as continue with what they're doing

How much someone can cope with at a time, and how much they are able to integrate into their next attempt at a task will depend on the person. Sometimes changing one movement or action at a time is enough (Queensland Occupational Therapy Fieldwork Collaborative, 2007; Pedretti, 1996).

Cues and Prompts

Cues and prompts are signals that indicate when or where a response is appropriate. They lead someone toward what they should say or do, for example a mother reminding her child to 'say thank you' for a gift, is prompting, but asking the child 'now what do we say?' is more of a cue.

Often when retraining daily living skills clients may need a little help to guide them towards their goal or how to do something. You do not want to tell them exactly how to do everything, but a cue or prompt in the right direction may help them to continue or get past a difficulty in order to complete the task on their own.

Cues and prompts may take the form of:

- a single word
- a gesture such as a nod or shake of the head or pointing. For example, to redirect someone to keep them on task without becoming drawn into a conversation, you may just need to smile and tap or indicate the project they are working on
- a question encouraging the person to think again or consider something else that may be needed

Cues can also come from the environment around you. For example, a client who has difficulty working out how to make a cup of tea in the rehabilitation unit kitchen may perform this task much more easily at home. These so-called 'contextual' cues may help them start on an automatic process of boiling the jug, putting a tea bag in the mug and so on. Similarly, a client with cognitive impairments is having trouble working out

what a shirt is and how to put it on in a therapy gym, but may be better able to recognise it and put it on in the bathroom after his shower.

As an Allied Health Assistant you may be involved in supervising a client practising tasks or activities as part of the rehabilitation program devised by treating Allied Health Professionals. You may need to provide cues and prompts to keep the client on task, or to assist them to complete all the steps. As the client progresses, the frequency of cues and prompts should reduce. Your supervising Allied Health Professional will advise on the type and frequency of prompts and cues you should be providing for individual clients at each different point along their rehabilitation pathway.



Activity 14 – Providing Feedback

This activity builds upon Activities 10 and 11.



Case Study: John

John has regained some strength in his arms and is now keen to attend the occupational therapy session for a breakfast group.

Answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. Outline why constructive feedback is important for John. Give an example of how this feedback would be best given to John.

2. How would John react if he was given non-constructive feedback during the session?

Activity Analysis

Activity analysis is about breaking a task down into the steps or skills needed to complete that task. Occupational therapists will often specialise in this area.

When working with a client on a therapy activity, it is helpful if you can set it up for the 'best fit' between a task, the person, and their abilities. The aim is often to challenge a person's skills but not make too much so that the person is unable to complete the task or exercise. Often the therapist will try to set the person up to experience at least some success with the therapy exercise. Otherwise therapy can be a very frustrating, negative experience.



Give feedback to your Allied Health Professional if the therapy activity seems too hard or too easy for the client. The Allied Health Professional may suggest some changes you might make to ensure success of therapy activities.

To modify a task, the Allied Health Professional will consider the characteristics of the client, task, and environment around them. Often there are aspects of the task or the environment that can be changed to make the activity challenging yet achievable. A client's skills are expected to develop over time. Initially, you may be required to frequently modify the task and environment as necessary and as prescribed by the Allied Health Professional.

Some small modifications to therapy may be made independently by an Allied Health Assistant:

1. Modifying the Task
 - If a reaching task is too difficult for the person to grasp the cup in front of them, you can move the cup a little closer so they can achieve success at least some of the time.
 - It's the end of the day and the client is very tired. The cup may need to be closer to them than first thing in the morning.
2. Modifying the environment
 - The client you are working with is very easily distracted. Try sitting them at a table facing a wall or away from other people, rather than at a table with other people.
3. Modifying the person's skills
 - This is often a big focus of therapy.
 - This may involve practicing a certain skill e.g. getting a shirt on and off, before asking the client to shower and dress independently the next morning.

As the client's abilities improve over time, you may not need to adapt or modify to make tasks easier; tasks can instead be made a little harder by reverse processes to the methods described above. To stay motivated and interested in therapy though, everyone needs to experience some success. Make sure clients have a chance to feel that they have achieved success before making a task harder again (Polatajko & Townsend, 2007; Pedretti, 2001).

Adapting Exercise Programs

As an Allied Health Assistant, you may often be the one who is present while clients work through their exercise programs. How a client copes with these may vary from day to day. Hopefully overall you will see improvement over time.



When modifying an exercise program, first check with your Allied Health Professional which parts can be changed while still addressing the goal they are designed to work towards.

Altering the following factors can make an exercise harder or easier:

- number of repetitions that are done
- how many sessions of exercise are completed
- length of rest in between exercises
- resistance used or how much work each repetition takes (e.g. weight size, working against gravity or not)
- body position during the exercise e.g. standing up or sitting down

How hard you 'push' someone at their exercises is very dependent on the client you are working with at the time, remembering that this may vary for the client on a daily level.

You need to consider:

- medical condition
- mood
- motivation
- personality and response to being pushed to work harder
- client's preferred manner of working
- cultural influences



In some cultures, for example, it may be inappropriate for a young female staff member to tell an older male client what to do and how to do it. Allowing the client more choice in how they undertake their exercises; what order, how many exactly, where they do them, what music they exercise to and etc. may help restore more power and dignity to the client. If you are working with clients from different cultural religious or ethnic groups, a bit of background research can make sure that your interactions with clients are culturally appropriate and do not cause offence. There is a lot of useful information about cultural considerations on the Queensland Health's Multicultural intranet site:

<http://qheps.health.qld.gov.au/multicultural/home.htm>

Some clients will respond well to coaching, such as encouragement, or reminders to complete the set number of exercises. Other clients may prefer to work through a difficult stage on their own. For example, if a client is already very tired or very emotional you may not wish to push them to complete their exercises. If they are feeling well and will be able to rest for most of the weekend afterwards, you may decide to encourage the client to undertake more exercises.

If there is ongoing difficulty for the client to complete the rehabilitation program set, you will need to consult with your Allied Health Professional. Together you may be able to determine the best way to adapt the program while continuing to address the client's goals.



Activity 15 - Conducting Rehabilitation Activities

Answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. How might you help someone who is having difficulty working out how to make a cup of tea?

2. What cues or prompts would you use?

Activity continues on the next page.

Theoretical Approaches to Rehabilitation

Compensatory versus Rehabilitation Approaches – When a person's abilities are unlikely to or do not improve enough to allow them to complete a task, a change in focus may be needed. Compensation for loss of skills will then be required. The task itself, environment or equipment used may be changed or adapted so the person can still achieve the goal.

For example, if someone is unable to walk again a wheelchair will be required. If they are unable to hold a spoon to feed themselves, special cutlery and a strap to hold a spoon to their hand may be trialled.

Strengths-Based Approach – This approach focuses on what is working well and what people can do. It assumes that people have the strengths and resources to solve their own problems, although they may require help to do so.



Critical to a strengths-based approach is empowering people to know what will work for them – they are the experts in their own lives.

Clients are encouraged to become drivers of their own recovery. That is, they are encouraged to help set their own goals, evaluate their own progress, and look towards the future. The emphasis is on the future, not dwelling on problems in the past (Staron et al, 2006; Cederbaum & Klusaritz, 2009).

Client Centred Approach – Modern rehabilitation involves the client (or their carer and guardian if appropriate) in identifying their main issues and functional problems with daily activities in work, self-maintenance, leisure and recreation, family and social roles. The therapist takes a long-term view of the client's needs and life outside the hospital.

For example, on discharges people may be linked with support services that can assist with a whole range of issues:

- transport
- accommodation
- meals
- housework
- shopping
- support groups where they can meet and talk to others facing similar challenges

(Polatajko & Townsend, 2007)

Goal Setting – A joint process undertaken by Allied Health Professionals and their clients, carers or families. It is seen as an important process in determining the focus, and in measuring the outcomes of rehabilitation.

You may hear Allied Health Professionals talking about SMART goals. These are goals which are:

- **Specific** – clearly set out and includes the who, what, when, where and why
- **Measurable** – so that you and the client are able to monitor and track their progress
- **Attainable or Attractive** – within likely reach and appealing to the client
- **Realistic** – the client is willing and able to work towards
- **Time-based** – a timeframe for the client to achieve

Example of a SMART goal

Specific	Walk to the dining room independently
Measurable	Walk for 10 minutes. Other measurable variables could include distance mobilised
Attainable or Attractive	Agreed goal between the OT and client. Client is currently able to do this in 12 minutes
Realistic	Client-focussed goal
Time-based	By the end of the week. This gives the client adequate time to practice and improve the skill.

Goals may be set around achieving a functional outcome e.g. to walk independently to the dining room in 10 minutes by the end of the week, or improving a skill e.g. dressing with 1 assist. Clients may have goals needing input from one allied health discipline e.g. to be able to shower themselves independently, or goals which might involve the whole rehabilitation team e.g. to be able to return to living at home. Rehabilitation works best when the team and the client work together on agreed goals.

As an Allied Health Assistant working with clients, you are in an excellent position to be able to talk about what a person wants to achieve in therapy. It is useful to regularly check that the person still has the same goals as initially identified. Priorities and the client's view of what they can or wish to achieve may be affected by their level of adjustment to their new condition. If the client is no longer interested in working towards a certain goal, it will be necessary for the rehabilitation team to refocus their therapy program and help the client establish other goals (Moodie, 2009).



Case Study: Adam

Adam is a client with quadriplegia due to a spinal cord injury. He is a very independent person by nature, and one of his stated goals is to become independent in dressing. After several weeks, and having seen other clients in the rehabilitation unit, he begins to accept that dressing himself will always take many hours each morning, and will leave him exhausted, with little time or energy for other things. He decides that he would prefer to be assisted with dressing by his wife.

A new goal is negotiated and the rehabilitation program is adjusted. The Occupational Therapist focuses on teaching Adam's wife how best to assist Adam with dressing.



Activity 16 - Goal-Setting

Answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. You are working with a client who has reduced fine motor co-ordination in their left hand. This client has difficulty with dressing tasks (such as buttons and zips), handwriting, and cooking tasks (such as opening packages and using cutlery). Write 3 SMART goals for this client.

i)

ii)

iii)

2. Select one of these goals and describe it in terms of the SMART model.

Specific	
Measurable	
Attainable or Attractive	
Realistic	
Time-based	

Monitoring Progress

Referring back to the client's goals or recording progress in objective ways is important to determine if the client is improving or changing. This is why setting goals that are objective and measurable is so important.

Because Allied Health Assistants often work so closely and regularly with clients, you may be the first to identify an unmet need. Client needs can be very complex and it is possible that a problem or need may not be immediately identified, or may become evident over time as the client tries to resume former roles or activities. Clients or families may confide in you if they feel there is something missing from the rehabilitation program and that they need something else. It is important then that any concerns are reported immediately to your supervisor.

A client's needs will also change as rehabilitation progresses. A client's safety is the key throughout this process, as is the prevention of further complications. For example, pressure relief equipment may be required for clients who cannot move to relieve pressure on their skin themselves. This may be taken away when the client recovers and starts to move around more independently. Allied Health Assistants need to report any safety concerns or observed complications to the appropriate Allied Health Professional.

Rehabilitation aims to address all aspects of a person's life:

- self care
- productive activities or work
- leisure or hobbies
- family and social roles

At different times one may take priority over another, so one problem may be left for a while as other major issues are addressed.

Motivating and Encouraging Client Participation in Therapy

What helps:

- Buddy-up or group work; having others to work with can make it fun.
- Having motivating, realistic and achievable goals
- Record keeping or tracking of progress towards goals. Point out any small improvements or a good effort as you notice them
- Explain what you're going to do and why
- Keep activities meaningful, interesting and age appropriate
- Listen to their story or objections; if they don't want to participate, try to find out why

- Keep a positive attitude towards your work and the people around; smile, make encouraging comments, use gentle touch as appropriate, and pay attention to clients' work
- Keep a positive environment to work in e.g. try music, encourage joking and laughing
- Allow balance of rest and work i.e. let people take a short break for rest, food or toileting as needed
- Allow some choice in activity as able e.g. order of activities
- Allow people to make mistakes at times and give them the opportunity to fix a mistake themselves (if safe to do so)
- Involve family and significant others in therapy sessions; ask them to provide sincere positive feedback for a person's efforts

(Pedretti, 2001)

Empowering your client

Allied Health Assistant's form a partnership based on the achievement of an agreed goal of improved functional status. For example, the goal may be to improve handwriting to enable a child to participate in classroom activities.

In forming an effective partnership, it is essential that all members are aware of their rights and responsibilities to ensure the outcomes of the service are safe, equitable, efficient, respectful and effective for everyone. It is important that you ensure the client understands their rights and responsibilities on your first contact with them.

Providing the client with their rights and responsibilities is an important step in empowering them to become an active member of the partnership. This will maximise their participation within the developmental program.

Things you can do to support the rights of your client when delivering a rehabilitation program include:

- encourage independence
- allow the client to decide who they want with them
- allow the client to wear their own clothes if they don't restrict your care of them
- allow the client to choose a male or female Allied Health Assistant if available
- allow the client to ask questions in regards to their care
- allow the client to take part in decisions
- provide easy-to-understand information about the client's treatment, including risks and other choices
- the right to a second opinion
- the right to give a compliment or make a complaint
- the right to have personal information kept private and confidential

You will also have expectations of your client during the course of your rehabilitation program. These may include:

- the client needs to give you as much information as they can about their health
- the client needs to follow your instructions
- the client needs to tell you about any changes to their condition
- the client needs to be on time for appointments and let your health service know if they want to cancel, or if they change their contact details
- to provide respect to all people met in the course of their service provision this includes no harassment, discrimination, physical or verbal abuse
- to respect the confidentiality and privacy of others in the healthcare setting



Activity 17 - Promoting Client Participation (continued)

3. Aggression can be physical and verbal. What would you do if a client became verbally or physically aggressive towards you whilst you were providing a treatment program? You may find it helpful to refer to Queensland Health resources on Occupational Violence Prevention.

http://qheps.health.qld.gov.au/safety/occup_violence/home.htm

- a) Strategies for managing verbal aggression:

- b) Strategies for managing physical aggression:

Activity continues on the next page

Evaluating and Ending Therapy

Once a client has achieved their goals, it is time to review their program. Together with the team, consider whether to continue with therapy or not. Generally therapy is brought to an end once the client has 'plateaued' in their progress. This means there are no, or few, substantial gains being made.

Therapy may also be ceased when progress is so slow that it will take more input and time than it is worth to the client to achieve such a small amount of improvement. This measurement is usually made against goals that have been set for the client, or specific records of movement, walking distance, ability to perform a task independently for example.

The end of therapy can be a traumatic time for a client. It is confronting for people to realise that certain abilities are probably not going to return. Clients may be desperate to continue despite evidence or records that their skills are not improving with therapy. For example, their ability to pick up a cup may not have changed for the past month despite daily work on this.

Arranging discharge is another reason for maintaining clear records on progress towards goals. Clients may strongly resist being discharged from a therapy program if it means that there is now little hope of significant improvement. Tactfully demonstrating that a particular ability is not changing any more (e.g. the distance they can walk or their ability to cook a meal) may be required to explain to a client why their rehabilitation program is to cease. Encouraging and highlighting potential for improvement in other areas of their life may be helpful, such as getting home from hospital and having time to restart leisure activities

It is of course best to review or evaluate the therapy program regularly to assess if there are any other reasons for the person not progressing. Together with your Allied Health Professional, check if the exercises or activities are appropriate for the goals set, whether or not the exercises are too hard or too easy for the person and whether or not the person has actually completed them as intended.

Educating Family and/or Carers

Frequently in rehabilitation, the family and carers are just as much a client of the service as a client may be. A major injury to someone will have a major impact on their loved ones or dependents as well. Family and carers also need information about the condition, equipment, and discharge plans. They may need to have this explained a number of times, as people under stress tend to absorb information less effectively. Providing information in writing, such as lists of equipment and where to get it, is often helpful.



Once the client leaves hospital, family often become the main support. Making sure the family or carer feel comfortable helping the person or that they are doing so safely is very important. Providing opportunities to practice tasks while in hospital, whilst there are staff around to ask questions or help if things go wrong is very important. Trials at home such as home visits, weekend passes or day leave can also be helpful to identify any problems and sort them out before the person is home permanently.



Activity 18 - Discharge planning

This activity builds upon the case study in Activity 10, 11 and 14. Answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.



Case Study: John

John is now approaching discharge from the hospital. He is now independent with transfers including bed to wheelchair transfers. John is mobilising independently in the wheelchair and is showering independently. He has 3 steps into a low-set house.

1. What are some of the considerations that the Occupational Therapist would have to make before John returns home?

2. Thinking about the whole healthcare team (both hospital-based and community care), what are some of the follow-up services John may require upon discharge?

Communication

Communicating clearly with staff, clients and their families and carers is a key skill when working in a rehabilitation team. A large part of communication is through body language, not just what we say.

Clients in rehabilitation may have difficulty with communication for a wide range of reasons including:

- Poor hearing or vision
- Brain injury affecting ability to process information or understand spoken language
- English is not their first language
- Impairment in muscles used for speech , causing slurring, also known as dysarthria
- The part of the brain that deals with language has been damaged and they struggle to form sentences or find the right words to say
- They may be upset or depressed and not want to talk to anyone

When speaking with clients who have communication difficulties, it may help to:

- Keep your sentences short and use simple words
- Check that the first part of an instruction has been understood before continuing
- Speak clearly and slowly
- Avoid unnecessary information or distracting detail, stay on topic
- Use hand gestures and body language to give the person extra cues as to what you are saying
- Give the person plenty of time to take in and process information or respond
- Don't complete sentences or fill in words for the person unless they indicate they'd like you to do this
- Encourage the person to communicate even if this takes a long time
- Ignore inappropriate or excessive swearing as this may be related to their medical condition
- If you have a lot to say, choose a quiet time and place
- Some people may use communication devices, such as a board with symbols on it or a small computer device to communicate



Avoid being condescending or treating an adult client like a child. Be sensitive – the person may be very frustrated when trying to communicate (Speech Pathology, 2009).

Communication Strategies

To show you are listening:

- Maintain eye contact as appropriate (consider cultural differences and preferences)
- Face or lean towards the client slightly
- Ask occasional questions and repeat back short words or phrases of what they are saying
- Use positive facial expressions e.g. smiling
- Agree as appropriate with what they are saying e.g. 'uh-uh, I see, umm', nodding
- Give them time to respond or complete their sentences
- Summarise briefly what the person has said and check that this is what they meant

Good communication skills are essential for establishing rapport. Rapport is about useful communication, and a harmonious relationship or connection with others. Rapport will help to establish trust between yourself and clients, many of whom are in a very vulnerable situation. Two people who have good rapport may mirror and match each other in posture, gesture and eye contact. The language or type of words they use when speaking may also be similar.

Communicating with clients from a non-English speaking background:

- Use as many non-verbal (non-speaking) cues as possible e.g. demonstrate a task then indicate for the person to copy you.
- Encourage family to visit or phone and assist with translation regularly.
- Ask family members to write a list of basic words in the client's language and the English translation.
- Try a communication board with symbols for basic needs e.g. toilet, food and drink.
- Be aware that people may not always admit or realise they have not fully understood what you said – for example, some may say 'yes' although they do not understand what you have said.
- Access formal translator services, which may be available via telephone or in person.

(Australian Flexible Learning Framework, 2008)

Communicating with the Team

When speaking with staff, you may choose to use more formal language and medical terminology than you do with clients.

Regular, informal and formal communication is key to effective teamwork. It will be useful to arrange specific times to meet with team members. For example, arranging a time each morning with your supervising Allied Health Professionals to check your planned schedule and adjust for any changes. In healthcare it is important to remain as flexible as possible. Unexpected issues may come up every day or mean you have to



rearrange your timetable. For example, clients or staff may be unwell, or more time may be needed to arrange community services than previously expected.

Being open and approachable to other members of the care team may also facilitate sharing of information. A simple 'hello' or acknowledgement of other people's presence will often let them know you are open to talk to, and encourage them to share many small but important details about a client, for example, that he is very tired already after a demanding physiotherapy session, or is feeling unwell or upset about something.

Reflective Practice

Looking back on your actions or sessions and how a client reacts to these is a very useful way to identify a need for change. Pay attention to what you do, and try to set aside some quiet time to think about and question what had happened.

Some useful questions to ask yourself when reflecting on your practice may include:

- Were there good or bad outcomes?
- Is there a common pattern or principle involved, or was it something individual to that person, place and time?
- What would you do if you were in that situation again?
- What would you do differently next time?



Previous experience can be an excellent guide for future directions or decisions. Consider factors in yourself, the client, the task, the environment, or the technique used to make a difference.

This can also be useful if done briefly during sessions – requiring ‘thinking on your feet’ as well as once a session is over.

Try discussing ideas or seeking feedback from others. Watching others work (with their permission) or asking others for suggestions can also be helpful. For example if you are having difficulty working with a client for some reason, it is useful to reflect and ask others for ideas on what could make sessions run better (Pedretti, 2001; Catlin & Vittner, 2009; Trombly 1995).



Activity 20 - Reflection

Reflect upon the situation below and answer the questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. Think of a therapy session you have been involved with when the session went well. What were some factors that contributed to the success of that session? Discuss the session's success in terms of the person, place, time and task.

2. Contrast this to another time you were involved in a session that didn't go well. What were the differences? Was there anything you could control? Consider planning, equipment and communication factors.

Key Points

- Rehabilitation needs to be holistic and consider or address all aspects of a person's life:
 - physical
 - cognitive
 - psychological and social
- Every person is an individual, with different goals, challenges and cultural backgrounds.
- The person's illness often has a big impact on the family or carers lives.
- Clear, sensitive communication is very important when working with clients and other staff.

3. Service Provision

This topic covers information about:

- Information and Resources
- Client Care Model
- Scope of Practice

Activities in this topic cover the following essential skills:

- Work under direct and indirect supervision
- Communicate effectively with clients in a therapeutic/treatment relationship
- Communicate effectively with supervisors and co-workers
- Work within a multi-disciplinary team
- Time management, personal organisation skills and establishing priorities

3.1 Information and Resources

There is a lot of information and resources available for rehabilitation clients. The internet allows quick access to information from across the world – much has been published on clinical treatment, support, equipment, personal stories and experiences of individuals who have undergone rehabilitation.

For some specific questions, you can try:

- other hospital and rehabilitation centres
- Allied Health Professionals and their relevant professional organisations. There may be a special interest group for rehabilitation which can assist
- diagnosis-specific organisations such as The Stroke Association, Aphasia Association
- local support groups and community health centres

Other sources of information include:

- your hospital library. Most research and journal articles and books are kept online; libraries will still have books on a wide range of topics. Ask the librarians – they can often quickly search databases or find relevant books for you
- Allied Health Professional departments will usually have a collection of text books they use regularly or Allied Health Professionals themselves may keep some basic or specialised textbooks relevant to your clinical area.

- Queensland Health Intranet site - Clinician's Knowledge Network (CKN). This is the starting point for access to many on-line textbooks and journal databases including medical dictionaries and drug information. Ask the librarian for tutorials or assistance on searching for information or using this site.
- general internet searches. These often reveal a broad range of information from recent evidence-based practice to local organisations. Websites may be reliable and informative websites, or published by individuals about their own personal point of view on a topic. Check the author and the date where possible to assess whether the information is current and valid.
- companies who sell rehabilitation equipment. These businesses often have representatives who will come out to your centre to display or trial items for you. They will generally have online or hard copies of catalogues also with pictures of equipment. Local businesses may be found in the phone book under 'disability equipment' or similar headings.
- Organisations as a source of information:
 - LifeTec – Each state in Australia has a government-funded centre that displays and allows trial of aids and equipment for daily living. Devices and information on them including suppliers and cost are available for all types of problems, from specialist furniture to assistive speech devices. LifeTec's website www.lifetec.org.au allows online searching for information on equipment
 - TADQ (Technical Aid to the Disabled, QLD Inc) – This volunteer organisation can make specific, unique pieces of equipment or modify items for those with special needs. For example, they may mount a special bracket for a feeding device to enable a person in a wheelchair to feed themselves off the wheelchair tray. For contact details look up www.tadq.org.au

Other useful information sources

Centrelink – Caring has many direct and hidden financial costs, which can stretch the budget. Financial assistance is available to help offset some of the costs. Centrelink offers payments to help people who are caring for someone who has a severe disability or medical condition or who is frail aged.



For further information on Centrelink's services:

Telephone: 13 2171

Web: www.centrelink.gov.au/internet/internet.nsf/home/index.htm

Carers Australia – The purpose of Carers Australia and the network of carers associations in each state and territory is to improve the lives of carers.



For further information on Carer's Australia:

Telephone: 1800 242 636

Web: www.carersaustralia.com.au

Commonwealth Carer Respite Centres – This service provides information on respite accommodation facilities for those with a disability.



For further information on Commonwealth Carer Respite Centres:

Telephone: 1800 059 059

The Commonwealth Carelink Centre – Provides a central point of contact to find out about services, supports and assistance in your area.



For further information on Commonwealth Carelink Centre:

Telephone: 1800 052 222.

Commonwealth Home Support Program (CHSP)

This is a government funded service providing assistance in the home, including help with personal hygiene, cleaning, respite, transport, and food preparation. There may also be community allied health services funded by CHSP. The service may actually be provided by a number of different non-government, not-for-profit organisations such as Blue Care, Spiritus and OzCare or by a local HACC service. There may be different 'packages' of care available. These will usually be arranged by the discharge planning co-ordinator before a client leaves the hospital.

Home Assist Secure

A government funded service that assists the frail, aged or disabled to complete minor home maintenance tasks such as repairing locks, installing security screens and lighting. The Home Assist Secure service will also complete home modification work recommended by an Occupational Therapist such as installation of grab rails or construction of ramps. They may assist with finding reliable tradespeople or help fund major modifications such as necessary bathroom renovations.

Support Groups

There are many support groups for all kinds of specific illnesses or problems. Local free newspapers often publish meeting times for these groups or the local library may also have information on council programs that could be relevant to your clients. Most areas will have a stroke support group or carers support group.

As an Allied Health Assistant you may be involved in gathering information or maintaining a database with information about relevant services in the community.

Medical Aids Subsidy Scheme (MASS)

This is the Queensland Health funding scheme to assist with funding for large, necessary pieces of equipment for people with a disability or pension card. Allied Health Professionals are required to trial the actual model or type of equipment required with the person, fill out application forms, and check the equipment is correct and works for the client.

To ensure correct prescription of what can be very expensive items e.g. power wheelchairs, the MASS website and staff provide information sessions on equipment and how to assess what will best suit the client.

As an Allied Health Assistant you may be involved in tracking and following up on MASS and other funding applications to ensure that equipment is received in a timely manner to enable client discharge from hospital.

3.2 Client Care Model

Queensland Health (2000) defines a model of care as; ‘...a multifaceted concept, which broadly defines the way health services are delivered’. It often describes what service will be delivered, how, by whom, and where the service will be delivered. For example, the ‘Rehabilitation Unit Model of Care’ for The Prince Charles Hospital, outlines the service that clients and their family can expect from the Rehabilitation Unit.

- A model of care may describe:
- what services are provided
- who provides the service (which workforces)
- when the services is provided
- how the service is provided

(Queensland Health, 2000)

There are many theories and concepts that drive the general approaches a team will take to rehabilitation. Some are concepts which cross all allied health professions and relate to the idea of rehabilitation in general. Each profession will have their own models and theories from which they work, which is the basis for the differences between the professions and their approach to solving a problem (Pedretti, 1996).



Often, you will operate in a service that follows multiple models of care. Specific model(s) will differ between work settings, so remember to ask the supervising Allied Health Professional to clarify which models are used.

Rehabilitation Model

This model emphasises working with a person on their ability to live and work with remaining capabilities. A client will be assisted to learn how to work around or compensate for physical, cognitive and perceptual limitations. The focus is on performance areas or occupations such as self-care, leisure and work. There will be less attention to the components that are used to complete performance such as thinking skills or physical abilities.

Using this model, a therapist will work on minimising barriers to role performance such as the physical environment or equipment design. An example of this would be changing the kitchen bench height so a person in a wheelchair can reach to do the cooking. This approach is often used in combination with other models, for example, a biomechanical model. It is always important to consider the potential for improvement

in a person's abilities. A biomechanical model would look at a person's physical abilities and how to improve them. For most clients, restoration of sensorimotor, cognitive and psychosocial functions is required to improve function.

Occupational Therapy Models of Practice

There are a number of different Occupational Therapy models of care, and again, the specific model used will differ between service areas. Some examples of the models are: The Occupational Performance Model (Australia), The Model of Human Occupation (MOHO) and the Canadian Model of Occupational Performance (COPM).

One thing that all of these models have in common is that they view the health of a client as being influenced by many factors including; environment (physical, social and cultural), personal skills and abilities (cognitive, physical, emotional and spiritual) and the task which they aim to perform.

Occupational Therapy models focus on the interaction and balance between the many factors that affect a person's ability to complete a task or perform their chosen 'occupation'. Occupations are often grouped into self maintenance, leisure and work. Self maintenance refers to daily living tasks such as paying bills, managing money, using the telephone, getting around and etc. (Christiansen, Baum & Bass-Hauge, 2005).

Leisure consists of things people do for pleasure including hobbies, sports and reading. Work or productive occupations covers paid or volunteer work, and may include tasks like driving, typing, and communicating with other people.

The models may vary in their view of exactly how the different aspects of people's lives can interact. Aspects of life that are acknowledged in most models include:

- the environment (physical, cultural, social and time)
- the person's abilities, skills or life stage (cognitive, physical, emotional and spiritual)
- the task or occupation (self care, productivity and leisure activities)

All these parts of a person's life interact with each other and a problem in one area can affect all other areas of a person's life. For example, being in pain can mean a person becomes depressed. They may then not bother showering or grooming themselves as well as usual. This can affect relationships with other people, performance at work, or motivation to participate in hobbies.

Similar frameworks are used to analyse a person's performance of their occupation or a task, to identify problem areas such as why someone can't pick up a cup. Your analysis of the situation may include exploring the following ideas:

- is it because they don't want to pick up a cup and drink independently?
- if they are ill, does their cultural background tell them that their family should be doing that for them?
- are they too weak to pick up the cup or can they not see well enough to reach it?



The framework will then be used to plan how to improve performance of a specific task or skills (Pedretti, 1996; Polatajko & Townsend, 2007).

The Interaction of Models

As most healthcare services will employ more than one model of care, you will need to understand how models of care link up with one another. The model below shows an example of how several models of care overlap with each other to shape the service that clients receive.

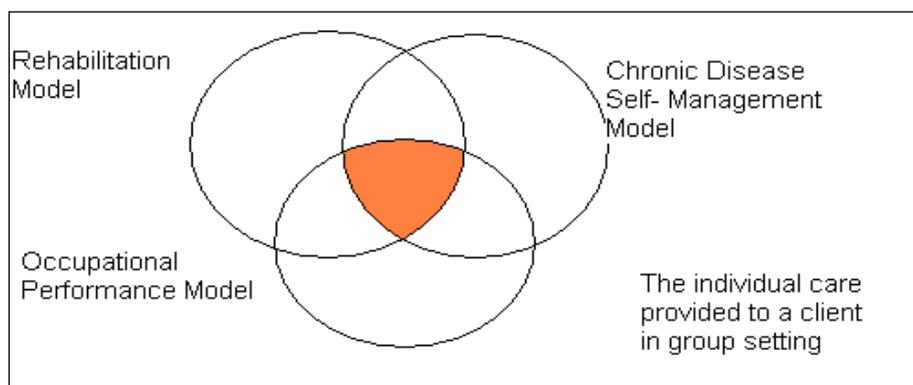


Figure 3 Interaction of Models

It is important note that the models are not always equally aligned. In some services, one model might be more central than others.



Some additional models of care that you may encounter in group work include:

- Case management model
- Slow stream rehabilitation
- Allied health assistant model (still in draft form at present)



Activity 22 – Client-centred Model

Imagine you work in a setting where therapy and intervention is highly client-centred.

Answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide. You may find it helpful to refer to “what is person-centred health care: research review and practice perspectives” at: http://www.powershow.com/view/3d448f-YmQ5M/What_is_person-centred_health_care_Research_review_and_practice_perspectives_powerpoint_ppt_presentation

1. What is a client-centred model of care?

2. What are the benefits of using client-centred models when planning interventions?

How do you ensure your treatment continues to be client-centred?

3.3 Scope of Practice

Scope of practice is the range of responsibility, e.g. types of clients, duties and practice guidelines that determine the boundaries within which an Allied Health Assistant works. All care delivered by an Allied Health Assistant needs to be within that individual's scope of practice.

The activity should be an activity that the Allied Health Assistant is trained, competent and authorised to perform. All delegated tasks must be appropriate for the Allied Health Assistant's role description and responsibilities. It is the responsibility of the Allied Health Assistant to inform the Allied Health Professional if they feel a task is outside their scope of practice.

As an Allied Health Assistant, your role will be varied depending on which profession/s you are assigned to assist. In general, the Allied Health Professional will assess the client and design programs for you to carry out. Clarifying exactly what is and isn't your job may take a little while to work through when you first start. Your job description and the instructions of staff should give you a clear idea. However, in rehabilitation, there is often no clear end to how much can be done for a client, which can cause confusion and stress for staff. There is often a lot that can or should be done for a person but limited time to do it in.

A clear timetable or schedule and checking in regularly with your supervisor/s can help you to manage your time. Learning to politely but assertively say 'no' may be necessary at times, particularly if you have a number of different supervisors to work with. An explanation of why you don't have time such as having other commitments, and an offer to negotiate another time or way to complete the task is usually helpful.

The ability to work efficiently and learning to prioritise the most important tasks is often the key to succeed in an Allied Health Assistant position.

Tasks you may be expected to do:

- arrange for clients to complete checklists or help them fill out self-report type assessments and forms
- complete administration tasks such as filling out equipment application forms
- prepare for and run individual or group therapy sessions, with program designed by Allied Health Professional
- make minor changes to therapy programs as required or with guidance from Allied Health Professional
- feedback on client condition or success of therapy sessions to Allied Health Professional
- order and maintain equipment, supplies and tidy work areas

- complete ADL re-training activities with clients
- monitor client progress in therapy programs
- accompany therapists on and assist with home visits
- apply assistive aids to clients
- arrange for equipment prescribed by Allied Health Professional
- provide education to clients and families, including practicing client care with them e.g. dressing and transfers
- attend department meetings and in-house training sessions
- contribute to department quality improvement activities

Queensland Health's Public Patients Charter

The Australian Charter of Healthcare Rights booklet will assist you with outlining to the client both of your rights and responsibilities. You will need to ensure your client has received a copy of the brochure and understands their rights and responsibilities at the start of their treatment program.



Copies of The Australian Charter of Healthcare Rights can be found on:

<https://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/>

This document is supported by Queensland Health.

Ensure your client has received a copy and understands their rights and responsibilities.

Queensland Health (2008) Models of Care draft role description outlines that the purpose of the Allied Health Assistant is to '...contribute to patient care by providing clinical support tasks delegated under the direct or indirect supervision of an AHP'. This explanation of the Allied Health Assistant role highlights some important issues regarding the Allied Health Assistant scope of practice:

- delegation
- supervision
- role within the health care team
- personal organisational skills

Delegation

Working alongside Occupational Therapists (OT) to assist clients to achieve their individual outcomes, will include the OT delegating tasks to you. When delegation occurs, both Allied Health Assistants and Allied Health Professional have responsibilities. The table below summarises some of these responsibilities.

AHA Responsibilities	AHP Responsibilities
<ul style="list-style-type: none"> • must have the appropriate level of experience and competence (i.e. skills and knowledge) to carry out the activity and the activity should be within the scope of the allied health assistant role. • has responsibility for raising any issues related to undertaking the delegated task, and should request additional information and/or support as required • should be aware of the extent of their expertise and scope of practice at all times and seek support from allied health professionals as required • shares responsibility for raising any issues and requesting additional support throughout the delegation and monitoring process. 	<ul style="list-style-type: none"> • establishes diagnosis, clinical management and treatment plans • should only delegate activities that are within the scope of their own professional practice and • that they are competent to assess, plan, implement and evaluate • must only delegate activities that are within the scope of practice and level of competency, • previously demonstrated experience and/or training and qualifications of an AHA • should determine whether it is appropriate to delegate a task to an AHA and only delegate • If/when it is appropriate is able to provide the type and frequency of monitoring (i.e. task supervision) the activity requires.

(AHA Framework, AHPOQ, 2016)



At no time should you be requested or required to undertake a task that is outside your level of competence or that is not identified by the Allied Health Assistant position description.

Supervision

Supervision refers to the monitoring, advice or instruction from another person to ensure optimal healthcare is provided to clients. The Allied Health Professions Office of Queensland (APHOQ) Allied Health Assistants Framework state that:

- AHA positions are to be clinically supervised by an allied health professional.
- AHA positions will have a designated clinical supervisor.
- Formal supervision sessions will be documented in accordance with local requirements.
- Clinical supervision may be direct, indirect and/or remote.



The two forms of supervision most commonly experienced by Allied Health Assistants are 'formal' and 'informal' supervision.

Also known as professional supervision (Queensland Government, 2011b), clinical supervision can be defined as a formal process of support and learning that involves:

- developing a mutual commitment between the AHA and allied health professional to reflect on the clinical practice of the AHA
- developing knowledge and skills competence
- clarifying boundaries and scope of practice
- planning and using personal and professional resources
- identifying training and education needs
- developing accountability for work quality (Queensland Government, 2010a).

Though an assistant should only have one primary clinical supervisor, there may be several allied health professionals of the same or different disciplines who delegate tasks to the assistant (Queensland Government, 2010b). Clinical supervision should be undertaken by an allied health professional although a senior AHA may co-supervise in collaboration with an allied health professional in some work units. Where an AHA is new to the service and/or the particular clinical area, they will initially require more frequent clinical supervision. It is the responsibility of the supervising and/or delegating allied health professional (potentially the same person) to:

- assess and verify the AHA's competency within the clinical context
- define and clarify the tasks to be undertaken by the AHA within their scope of practice
- ensure the AHA has a clear understanding of the tasks to be undertaken within that context.

Delivery of clinical supervision

Clinical supervision can be delivered either directly, indirectly or remotely:

- Direct clinical supervision occurs when the supervising allied health professional:
 - works alongside the AHA
 - observes and directs the AHA's activities
 - provides immediate guidance, feedback and intervention as required.
- Indirect clinical supervision occurs when the supervising allied health professional:
 - works on-site and is easily accessible, but not in direct view of the AHA while the activity is being performed—the AHA must rely on clear communication from the supervising allied health professional
 - is readily available within the same physical area or easily contactable (i.e. by phone or pager) should the need for consultation arise
 - designates an alternative contact person (should the need arise) if they will be unavailable.
- Remote clinical supervision occurs when the supervising allied health professional:
 - is located some distance from the AHA

– is contactable and accessible to provide direction, support and guidance as required (e.g. telephone or video-conferencing).

(AHA Framework, AHPOQ, 2016)

Working with your supervisor

Communication – Regular communication is the key. Work out with your supervisor the best method of communicating with them. Have an agreement around how often, what method, and where you will meet to communicate.

For example, try:

- telephone, e-mail or weekly meetings if you are at different sites
- use set forms or leaving notes or reports for each other. Make sure there is a special place e.g. desk, pigeon hole, or in-tray to leave any written information
- regular meetings with your supervisor/s to review what you are doing. This provides an opportunity to raise any questions or issues before they become a big problem. It can also be a chance for you to show how much you have achieved. In addition to a regular whole team meeting, try a quick scheduled catch up each morning just with your supervisor
- be aware that your supervisor is not a mind reader - state any concerns clearly as they come up
- if in doubt, ask
- if instructions are not clear to you, ask for clarification or repeat back to check if you have heard or understood correctly

Examples of inconvenient times to try and speak with your supervisor are:

- when they are clearly busy with a client, staff member or task
- right at the end of the day as they are walking out the door
- when they do not have the time or resources available to answer your questions

It may be okay to ask a simple question of someone working with a client, but this is not the time for long complicated questions or reporting a non-urgent problem. In particular, you must not discuss one client in front of another as this is a breach of confidentiality.

For urgent matters, know who else you can contact and how, should your supervisor be unavailable. In terms of what to tell your supervisor, the level of detail they need to know will vary depending on what you are doing. It may take some negotiation with your supervisor over time to establish exactly what they like to know. Each supervisor, Allied Health Assistant and situation will be different.

Key points to report will generally include:

- any risk to, or concerns about safety
- sudden changes, whether in a client's condition, abilities or your roster or demands on your time

- specific commitments e.g. a day off training with another profession
- need for training or if you are not confident with a technique or treatment you have been asked to use
- treatment programs requiring adjustment, whether because they are too easy or too difficult for clients
- queries about prioritisation of tasks and which are most important
-



Additional information regarding the Queensland Health Allied Health Assistant Framework can be found on the website:
<https://www.health.qld.gov.au/ahwac/html/ahassist>

Feeding Back About Clients

When providing feedback about clients; clear and concise is best. Plan or think about what you will say prior to feeding back to your supervisor. Try to avoid vague and irrelevant details. For example, if reporting a chat with a client you may report that Mrs G is desperate to go home rather than adding in exactly what she said about her cat and how cute he is.

Consider what your supervisor needs to know – usually this is about the general progress of a client and any changes to their condition. At times specific details may be very significant e.g. if a person could find the items to make a cup of tea without help or not. Your Allied Health Professional should tell you ahead of time which specific details matter and what to watch for, or they may ask for more detail if required.

Working in Care Teams

In your role as Allied Health Assistant, you may find yourself involved in a number of teams at any one time. This may include a ward team, occupational therapy departmental team and a professional team of Allied Health Assistants.

You will find your role varies within each team, but certain behaviours and skills will be necessary for you to be successful in each role. The teams will not be exclusive to client care. You may also find yourself involved in teams relating to projects and your department.

The most common models of teams in healthcare are:

- **The multi-disciplinary team** – In this team of health professionals each perform individual assessment and management strategies. Their recommendations are then pooled together to make an overall plan for the client.
- **The inter-disciplinary team** – In this team all health professionals consult with one another at all stages including assessment, planning and evaluation.
- **The trans-disciplinary team** – In this team, one team member acts as the primary therapist, and other team members provide advice and information through the primary person.

(Queensland Health Statewide Occupational Therapy Clinical Education Program, 2009)

Most commonly you will find yourself working within the multi-disciplinary team model within the healthcare setting.

Multi-disciplinary Team

A multi-disciplinary team (MDT) is a group of health professionals who meet to discuss all relevant treatment options and develop an individual treatment plan for each client. This joint approach allows the team to make decisions about the most appropriate treatment and supportive care for the client while taking into account the individual client's preferences and circumstances.

Teams can consist of medical staff, nursing staff, social workers, dieticians, speech pathologists, physiotherapists, Occupational Therapists and Allied Health Assistants (The Cancer Institute NSW, 2010).

Generally, each discipline conducts an independent assessment of the client. Then each discipline develops their treatment plans independently. One person, usually the physician, orders the services and co-ordinates the care. There may be meetings to discuss progress, however often there is little direct communication amongst team members. Team members work in parallel with one another and often the medical

chart serves as a vehicle to share information (Geriatric Interdisciplinary Team Training, 2001).

It is important for you to understand your tasks and responsibilities within each team you are involved in. Where appropriate you will need to lead departmental and team meetings, case conferences as well as other team projects and activities.

When an OT is unable to attend a case conference you may be required to attend in their place. To assist with this, the OT will provide you with the relevant information for each client. You will need to be able to interpret the information and present it in a manner that is meaningful to the team.

Team Member Roles

Medical practitioners or doctors (MD):

- diagnose, treat and assist in the prevention of human physical and mental illness, disease and injury and promote good human health
- are involved in a wide range of activities including consultations, attending emergencies, performing operations and arranging medical investigations
- work with many other health professionals

Nursing staff (NUM, RN and EN):

- provide care for clients in a variety of healthcare settings
- provide physical and technical care and support for clients
- take part in the daily ward round with other nurses, doctors and allied health
- ensure clients receive treatment prescribed by health professionals
- provide emotional and psychological support and information to clients and their families

Occupational therapists (OT):

- work with people of all ages with a variety of conditions caused by injury or illness, psychological or emotional difficulties, developmental delay or the effects of aging
- their goal is to assist individuals to improve their everyday functional abilities and enable independence, well being and quality of life
- help clients maximise function and enable participation in their own lives

Physiotherapists (PT):

- provide treatment for people with physical problems caused by injury, illness, diseases and ageing

- use a range of treatments including mobilisation and manipulation of joints, massage, therapeutic exercise, electrotherapy and hydrotherapy to reduce pain, restore function and improve an individual's quality of life

Speech pathologists (SP):

- assess, diagnose, treat and provide management services to people of all ages with communication and/or swallowing impairments
- work with people of all ages who have difficulties swallowing food and drink
- people seek the assistance of a speech pathologist if they have speech, language, voice or fluency difficulties which impact on their ability to communicate effectively

Social workers (SW):

- provide information, counselling, emotional and practical support
- their primary concern is to address the social and psychological factors that surround clients' physical and/or medical presentations
- also provide assistance with resourcing care packages, information and referral to community services, advocacy and practical assistance

Dieticians (Diet):

- health professionals who improve the health of individuals, groups and communities by applying the science of human nutrition
- use their skills and knowledge to modify diets to treat medical conditions, and to advise other health professionals about the role of diet in health care, as well as educate the general public about eating for health

Psychologists:

- are experts in human behaviour, personality, interpersonal relationships, learning and motivation
- play an important role in helping individuals to enjoy and improve their quality of life by assisting in the management of many common mental health disorders, and by equipping people with the skills needed to function better and to prevent problems.

(Queensland Health, 2008)

Allied Health Assistant Role within Care Team

Allied Health Assistants are an integral part of a multi-disciplinary team (MDT) and often off act as a 'lynch pin' within the team. This tends to occur when the Allied Health Assistant works collaboratively with multiple Allied Health Professionals.

Communication between you and the rest of the team is a vital component for effective team work.

Key responsibilities as a member of a care team:

- have a good understanding of the roles of your colleagues, both Allied Health Assistant and Allied Health Professional
- maintain regular feedback to Allied Health Professionals regarding client progress
- provide regular feedback to Allied Health Professional regarding your workload levels (are you run off your feet or could you potentially take on additional responsibilities?)
- maintain positive relations including open and honest communication and a constructive climate for discussion
- demonstrate a commitment for the team
- have organised procedures

Effective communication is the ability to convey your message to other people and have that message understood without any misinterpretation. The information transferred should:

- include all relevant data
- be accurate
- be unambiguous
- occur in a timely manner

This information enables actions to be taken to provide the care that a client needs. When providing feedback to the OT and the team about a client, it is important that you are able to provide a summary of the key points relating to your contact with the client. You will need to be able to identify what information is important to the continuing care of the client.

When appropriate, this may include attending ward team meetings and ward rounds with the team to assist with discharge planning and equipment, client education and home visits. You may also need to report back to the multi-disciplinary team and departmental team meetings as a representative of Allied Health Assistants.

Occasionally you may be required to provide feedback regarding a client's progress during team case conferences. The Allied Health Assistant Model of Care outlines that when an Allied Health Professional is unable to be present at case conference, the Allied Health Professional must supply or pre-approve the feedback that the Allied Health Assistant is to provide at the case conference. The Allied Health Assistant needs to be able to interpret the information and present it in a meaningful manner to the team.

Limitations of Role

The Allied Health Assistant should discuss with the Allied Health Professional if the delegated tasks are outside scope of role and responsibilities as defined by the organisation (role description). This may occur for a number of reasons:

- lack of understanding of the role (by the AHA or the AHP)

- the Allied Health Assistant may be new to the job and not have had all the required training.
- the Allied Health Professional may have worked in another setting where the Allied Health Assistant role was different.

This communication is to ideally take place as soon as scope-of-practice issues come up. However, it may be appropriate to discuss these issues in a formal meeting.

Non-clinical Responsibilities

Managing a complex environment of teams requires good non-clinical skills such as time management, personal organisation and prioritisation.

Time Management – This can be anything you do to organise your time in your day. Suggestions to assist with this include:

- plan and schedule activities e.g. use a diary and schedule in routine activities such as ward meetings
- delegate effectively
- be efficient e.g. one task at a time, handle paper and e-mails once only and learn to say 'no' when it is appropriate
- control the small things such as talking, day dreaming and over debriefing

Personal Organisation – Organise yourself both now and in the future. Strategies to assist with this include:

- effective scheduling e.g. block in essential tasks to complete your job, schedule in high priority tasks and ensure contingency time to handle interruptions
- use 'to do' lists
- action planning for the day, week and year prioritising what you need to achieve

Prioritisation – Determine which tasks need to be achieved and manage competing demands. Strategies to assist with this may include:

- scheduling as outlined above
- use of prioritisation policies and procedures
- recommendations from OT

(Queensland Health Statewide Occupational Therapy Clinical Education Program, 2009)



Activity 24 - Working with a MDT Part A

Respond to the following activity. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

From a multi-disciplinary team (MDT) perspective draw a flow chart that illustrates your role within your MDT. Include yourself and clients in this model as well as Allied Health Professional, line managers, dieticians, nurses and etc. In this flow chart indicate who you have direct and indirect supervisory responsibilities to.

Activity continues on the next page



Activity 24 - Working with a MDT Part B (continued)

The following is an observation activity to see how effective your team is. Complete the activity after attending a team meeting. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

Team Observation Tool	
Team:	Date:
Does this team have an apparent goal? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is the goal?	
Professional Goals	
Circle the disciplines attending the meeting	MD SW NUM RN Diet SP OT PT
Do team members appear knowledgeable about their roles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do team members appear knowledgeable about the roles of other disciplines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there disciplines participating in the team with whose roles you are not familiar with?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so which ones?	
Leadership	
Who is (are) the team leader(s)?	
Does the leadership change during the meeting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What behaviours do the leaders use (summarising, initiating...)?	

Activity continues on the next page



Activity 24 - Working with a MDT Part B (continued)

Communication and Conflict	
Is there any open sharing of information?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Note any barriers to communication you observe (side conversations...)	
Is there an opportunity for differences of options to be discussed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What are the examples of conflict?	
How were they handled?	
Meeting Skills	
How is the meeting organised? (agenda...)	

Activity continues on the next page



Activity 24 - Working with a MDT Part B (continued)

Outcome	
What was accomplished or produced during the meeting?	
Are decisions and next steps clear?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was the meeting efficient? Why	

(Long & Wilson, 2001).

Key Points

- Extra information and resources are available for staff and clients through a variety of ways e.g. internet, libraries, local newspapers, council pamphlets and other people who work in the area.
- The models of care used by your service and Allied Health Professionals will influence how they work with clients. Many Allied Health and rehabilitation models tend to be holistic, and try to take into consideration all aspects of a person's life.
- Client Care Principles:
 - Client-Centred
 - Occupational Therapy Models of Practice
 - Goal-Directed
- Queensland Health Models of Care (draft role description) outlines that the purpose of the Allied Health Assistant is to '...contribute to client care by providing clinical support tasks delegated under the direct or indirect supervision of an AHP'.
- All care delivered by an Allied Health Assistant needs to be within that individual's scope of practice
- Allied Health Assistant scope of practice:
 - Supervision
 - Delegation
 - Role within the health care team
 - Personal organisational skills
- Multidisciplinary Team may include Medical staff, Nursing staff, Social Workers, Dieticians, Speech Pathologists, Physiotherapists, Occupational Therapists and Allied Health Assistants
- What tasks you perform and what you don't do as an Allied Health Assistant will vary depending on where you work and your role description. You will need to clarify what you need to do in the job with your supervisor.
- Using time management aids such as calendars, diaries, lists and a regular schedule will help to make sure you manage to complete all your tasks in an efficient manner.
- Regular clear communication with your supervisor and other staff will help your day to day work to run smoothly.

SELF-COMPETITION CHECKLIST

Congratulations! You have completed the topics for Learner Guide: Assist with the rehabilitation of clients.

Please review the following list of knowledge and skills for the unit of competency you have just completed. Indicate by ticking the box if you believe that you have covered this information and that you are ready to undertake assessment.

Assist with the rehabilitation of clients

Essential Knowledge	Covered in topic
Working knowledge of principles and practices of rehabilitation	<input type="checkbox"/> Yes
Knowledge of codes of practice for work in occupational therapy	<input type="checkbox"/> Yes
Legal and organisation requirements on equity, diversity, discrimination, rights, confidentiality and sharing information when supporting a client on a rehabilitation program	<input type="checkbox"/> Yes
How to work with clients, carers and other members of a care team to assist with the development, regaining and retention of skills for daily living	<input type="checkbox"/> Yes
The impact of illness on daily living and working skills on clients, carers and others	<input type="checkbox"/> Yes
Working with clients, carers and others to: <ul style="list-style-type: none"> • Identify needs • Identify strategies to build on existing strengths and capacities • Evaluation of progress • Unmet needs 	<input type="checkbox"/> Yes
Access to resources, aids and information for rehabilitation programs	<input type="checkbox"/> Yes
Strategies to support, motivate and encourage clients in a rehabilitation program	<input type="checkbox"/> Yes
Understanding of role within a care team and when and how to provide feedback about the client	<input type="checkbox"/> Yes
A working knowledge of record keeping practices and procedures in relation to rehabilitation programs	<input type="checkbox"/> Yes

Essential Knowledge	Covered in topic
OHS policies and procedures that relate to the Allied Health Assistant's role in implementing rehabilitation programs	<input type="checkbox"/> Yes
Infection control policies and procedures that relate to the Allied Health Assistant's role in implementing rehabilitation programs	<input type="checkbox"/> Yes
Supervisory and reporting protocols of the organisation	<input type="checkbox"/> Yes
Understanding of quality assurance, best practice and accreditation standards	<input type="checkbox"/> Yes



Activity 25 - Questions

For this task you are required to answer questions that relate to your work as an Allied Health Assistant assisting with the rehabilitation of clients. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. Why is it important to develop client-centred goals?

2. Why is important to provide client with feedback of their performance during a rehabilitation program?

Activity continues on the next page



Activity 27 - Workplace Observation Checklist

You will be observed providing support to assist with the rehabilitation of clients. The learner may choose from the following rehabilitation programs:

Upper limb therapy program

Functional rehabilitation program (i.e. meal preparation/self-care retraining)

Community access program (i.e. using public transport, road safety)

You will need to assist with the rehabilitation of clients on at least two occasions to demonstrate competence.

WORKPLACE OBSERVATION CHECKLIST

Workplace supervisor to date and sign (draft only, please record in the Assessment Guide)

Essential Skills and Knowledge The learner demonstrates the following skills and knowledge	1 st observation date & initials	2 nd observation date & initials	Comments	FER
Plan to deliver a rehabilitation program				
<ul style="list-style-type: none"> • Liaises with OT to obtain information about the rehabilitation program 				
<ul style="list-style-type: none"> • Demonstrates an understanding of the benefits of a rehabilitation program for the client and identifies potential outcomes for the client 				
<ul style="list-style-type: none"> • Liaises with other team members or reads medical notes to gather relevant information about the client (i.e. speech therapist for communication, physiotherapist for mobility) 				
<ul style="list-style-type: none"> • Schedules time slots to see client (with and without OT). Liaises with other team members to arrange joint session if determined necessary 				
Assist with the development of a rehabilitation program				
<ul style="list-style-type: none"> • Assists OT in the assessment of the client (as directed by OT) to determine the clients current functioning (including cognitive, physical and psychological). • Liaises with OT after assessments to develop an understanding of clients current functioning and impairments. 				
<ul style="list-style-type: none"> • Assists OT to work with the client / family/ 				

Essential Skills and Knowledge The learner demonstrates the following skills and knowledge	1 st observation date & initials	2 nd observation date & initials	Comments	FER
significant others to develop client centred rehabilitation goals				
<ul style="list-style-type: none"> Assists OT to make referrals to other team members if client identifies goal areas outside of OT 				
<ul style="list-style-type: none"> Liaises with team to discuss OT goals and rehabilitation program 				
<ul style="list-style-type: none"> Demonstrates an understanding of what is required in each session with the client. Discusses with OT the possibility of encouraging client to participation in a home program and develop if appropriate. 				
Assist with the delivery of a rehabilitation program				
<ul style="list-style-type: none"> Gathers appropriate equipment / resources before session with client and checks equipment before use to ensure safe and clean to use 				
<ul style="list-style-type: none"> Obtains client consent to participate in the program 				
<ul style="list-style-type: none"> Provides appropriate and clear instructions to the client regarding the purpose of the program / session 				
<ul style="list-style-type: none"> Provides ongoing feedback to client throughout the session about performance and offers suggestions to assist with improving client performance and participation 				
<ul style="list-style-type: none"> Modifies program if client loses interest, activity is not appropriate, or becomes upset 				

Essential Skills and Knowledge The learner demonstrates the following skills and knowledge	1 st observation date & initials	2 nd observation date & initials	Comments	FER
<ul style="list-style-type: none"> Terminates session if concerns arise and/or client is unsafe or at risk 				
<ul style="list-style-type: none"> Uses appropriate communication for the client and maintains appropriate therapist – client relationships 				
<ul style="list-style-type: none"> Provides OT with feedback on client's performance within the session (including mood, motivation, progress and difficulties). 				
<ul style="list-style-type: none"> Assists OT to evaluate effectiveness of this program and offer suggestion / changes 				
Clean and store equipment and materials				
<ul style="list-style-type: none"> Cleans any equipment as required by hospital/ centres policies and procedures 				
<ul style="list-style-type: none"> Ensures equipment is stored in an appropriate place whilst not been used by the client (i.e. in a safe storage place so it is not an OHS risk) 				
<ul style="list-style-type: none"> Returns equipment to correct location once finished 				
Document client information				
<ul style="list-style-type: none"> Liaises with OT / team to provide feedback about clients program and progress 				
<ul style="list-style-type: none"> Documents sessions in the client in case notes/ medical records (including client's mood, motivation, progress and any difficulties / issues) 				
<ul style="list-style-type: none"> Documents and report to appropriate persons any broken equipment 				

*FER – Further Evidence Required

RESOURCES

Allied Health Assistance Documentation Manual. Models of Care: Meeting individuals and community needs through workforce design.

Web: <http://gheps.health.qld.gov.au/ahwac/docs/MOC/mocahagovguide.pdf>

Centre for Healthcare Related Infection Surveillance and Prevention (CHRISP)

Web: <http://www.health.qld.gov.au/chrisp>

Centrelink: Telephone: 13 2171

Web: <http://www.centrelink.gov.au/internet/internet.nsf/home/index.htm>

Carer's Australia: Telephone: 1800 242 636

Web: www.carersaustralia.com.au

Carer Respite Centres: Telephone: 1800 059 059

Commonwealth Carelink Centre: Telephone: 1800 052 222.

Queensland Health Allied Health Assistant Framework can be found on the website:

<https://www.health.qld.gov.au/ahwac/html/ahassist>

The Australian Charter of Healthcare Rights can be found on:

<https://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/>

GLOSSARY

Word	Definition
Cognitive	Memory, thinking and higher brain functions such as problem solving and judgement
Function	The ability to perform activities or tasks, usually in a normal or accepted way (Townsend & Polatajko, 2007)
Incident	A clinical incident is any event or circumstance that has actually, or could potentially, lead to unintended and/or unnecessary mental or physical harm to a client of Queensland Health. Clinical incidents include adverse events (harm caused) and near misses (no harm caused) (Queensland Health Client Safety Centre, 2009)
Near Miss	A near miss is any event or outcome that did not result in an injury, illness, property damage or adverse environmental impact but had the potential to. The difference between a near miss and an actual injury, illness, property damage or adverse environmental impact is often only a fraction of a second or a centimetre that may not be there the next time it occurs. A near miss is a warning of injuries, illnesses and damage to property or adverse environmental impacts. These warnings allow the opportunity to place controls in place to prevent an injury rather than waiting for an injury to occur before taking action. (Queensland Health Workplace Health and Safety, 2008)
Occupation	All the things humans do – including looking after themselves (self-care), enjoying life (leisure) and contributing socially and economically to their communities (productivity) (Townsend & Polatajko, 2007)
Perceptual	Ability to organise and interpret incoming sensory information e.g. vision, hearing, touch (Jacobs & Jacobs, 2004)
Psychosocial	Pertaining to interpersonal and social interactions that influence behaviour and development. (Jacobs & Jacobs, 2004)
Sensorimotor	Refers to sensory (vision, hearing, feeling touch) and motor (strength, mobility) skills people possess or use to complete tasks. Includes the combination of these for example strength hand-eye co-ordination is a sensorimotor ability. (Pedretti, 1996)

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